



House of Commons
Health Committee

After Francis: making a difference

Third Report of Session 2013–14

*Report, together with formal minutes and oral
and written evidence*

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Membership

Rt Hon Stephen Dorrell MP (*Conservative, Charnwood*) (Chair)¹
Rosie Cooper MP (*Labour, West Lancashire*)
Andrew George MP (*Liberal Democrat, St Ives*)
Barbara Keeley MP (*Labour, Worsley and Eccles South*)
Charlotte Leslie MP (*Conservative, Bristol North West*)
Grahame M. Morris MP (*Labour, Easington*)
Andrew Percy MP (*Conservative, Brigg and Goole*)
Mr Virendra Sharma MP (*Labour, Ealing Southall*)
David Tredinnick MP (*Conservative, Bosworth*)
Valerie Vaz MP (*Labour, Walsall South*)
Dr Sarah Wollaston MP (*Conservative, Totnes*)

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Committee staff

The staff of the Committee are David Lloyd (Clerk), Martyn Atkins (Second Clerk), Laura Daniels (Committee Specialist), Stephen Aldhouse (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5466. The Committee's email address is healthcom@parliament.uk.

¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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Summary

In this report the Committee gives its view on the principal recommendations of the report of the public inquiry into the Mid Staffordshire NHS Foundation Trust undertaken by Robert Francis QC. The Committee will be keeping the Government's response to the full set of recommendations made by Robert Francis under review as part of its ongoing programme of scrutiny.

The Francis report is important because it describes a culture in one part of the healthcare system where shocking and obvious deficiencies in care could persist unchecked, with completely unacceptable consequences for patients and relatives. As a consequence, a healthcare system established for public benefit and funded from public funds risks the undermining of its guarantees of safety and quality. It is vital that the pervasiveness of this culture in many parts of the health and care system is recognised and addressed: but it must also be recognised that the experiences of poor care at Mid Staffs are not the experiences of millions of patients treated each year by caring, experienced and committed NHS staff.

Robert Francis recommended that the Committee should, through its programme of regular accountability hearings and otherwise, monitor the implementation of his recommendations and the development of cultural change in the NHS. The Committee agrees, and plans to work with the Professional Standards Authority for Health and Social Care to enhance its oversight of the quality of regulation of the healthcare professions.

Legislation proposed by the Government in response to certain of Robert Francis's recommendations is contained in Part 2 of the Care Bill [*Lords*]. The Committee recommends that the Government respond to its report in good time for the response to be discussed at that Bill's Second Reading in the Commons.

Open culture and professional responsibility

Trusts and other care providers have a fundamental duty to establish and maintain an environment where the concerns about patient safety and care quality raised by clinicians or managers can be discussed openly and directly. The Committee recognises the unambiguous professional duty on healthcare professionals to raise concerns about the safety and quality of care delivered to patients: managers should also be expected to raise any concerns they have about the safety and quality of care openly and without risk of detriment.

The Committee considers that measures designed to strengthen a culture of candour in the NHS should require openness about the full range of outcomes achieved, not just about where things go wrong. More open accountability for outcomes achieved would spur improvements to the quality of care delivered across the full range of health and care facilities. An open culture which encourages challenge is fundamental to the delivery of high quality care.

The duty of candour on providers now written into the NHS standard contract appears to be based on sound principles, but experience shows that such principles have in the past

been too often honoured in the breach rather than the observance. Commissioners of NHS services have a fundamental role in ensuring that providers observe the duty of candour and the principles which underlie it. If a provider fails to be candid with its patients and the commissioner which funds it, this should be regarded as a failure of enforcement by the commissioner as well as a failure of performance by the provider. High quality providers can set the pace for openness and transparency by improving their disclosure of anonymised data on outcomes. Verbal commitments to higher standards are meaningless if no effective steps are taken to monitor performance.

The NHS Commissioning Board (now NHS England) has not applied a duty of candour explicitly to commissioners, a recommendation of the Committee's 2011 report on *Complaints and Litigation*. The Committee considers this to be a significant opportunity missed to promote a more open and accountable culture throughout the NHS: such a duty is vital to build public confidence in the commissioning system. Similarly, the revision of the NHS Constitution to reflect the new contractual duty of candour misses the opportunity to indicate that commissioners have a responsibility to ensure that providers of NHS care give timely, accurate and complete information to individual patients and to commissioners in all circumstances.

Defensive considerations driven by an over-legalistic culture in providers should not be allowed to impede the proper relationship between clinical professional and patient, nor should they impede the duty on Trusts to provide full and candid explanations to relatives bereaved as the result of an adverse incident.

Robert Francis argued for a statutory duty of candour owed by providers to patients. The review of patient safety in England led by Professor Don Berwick also supported a statutory duty of candour on this model, but entered reservations about its scope, since a requirement for automatic reporting of 'every error or near miss' could lead to substantial bureaucratic overheads which could detract from patient care. Berwick has recommended the commissioning of research into the proactive disclosure of serious incidents and engaging with patients about them. The Committee considers that undertaking this necessary activity should not delay the implementation of measures designed to entrench openness and candour across the NHS.

Robert Francis also argued for a statutory duty on healthcare workers to report beliefs or suspicions about serious incidents to employers. The Berwick Review did not support this recommendation, since the requirement was considered to be covered adequately by professional codes of conduct and guidance.

The Committee is not persuaded that a statutory duty defined in secondary legislation, operating in addition to existing contractual duties and professional obligations, will necessarily be effective in achieving cultural change at the scale the NHS requires, and is concerned that insufficient attention may have been given to how these proposed new arrangements will interact with existing processes.

Raising concerns and resolving disputes

Robert Francis has recommended a change in NHS culture to achieve a situation where it is easier and more palatable to raise a genuine concern about care standards or patient safety than not. The Committee agrees with this approach, though it recognises that individuals who do raise concerns may face serious consequences as a result. The management of each NHS provider has a duty to establish a culture where issues of genuine concern can be raised freely. The Committee considers that disciplinary procedures, professional standards hearings and employment tribunals are not appropriate forums for honestly-held concerns about patient safety and care quality to be discussed.

Providers of health and care services, and their regulators, should be open and transparent. Any 'gagging' clause in an agreement with such an organisation which has the effect of inhibiting the free discussion of issues of patient safety and care quality is unlawful, and no NHS body should seek to enforce any such agreement in a way which inhibits the free discussion of such issues.

The Committee makes no finding of fact in the case of Mr Gary Walker, former chief executive of United Lincolnshire Hospitals NHS Trust, who alleged that he had been forced to compromise patient safety to achieve hospital access targets. The Committee was nevertheless concerned that the Trust and its legal representatives showed insensitivity and a lack of discretion in seeking to restrain Mr Walker from giving a radio interview in which he planned to discuss his concerns.

The Committee has been pleased to receive an assurance from the incoming Chair of the Care Quality Commission that its standard compromise agreement with employees makes it explicit that such agreements do not prevent the raising of legitimate concerns through protected disclosures. The Committee recommends that the CQC write to each individual with which it has an existing compromise agreement to state unambiguously that the terms of such agreements will not be enforced on individuals seeking to raise concerns in the public interest through protected disclosures.

As many as 50 special severance payments made to former NHS staff may have escaped Department of Health and Treasury scrutiny, as they were agreed through a process of judicial mediation which had hitherto been deemed not to require the approval of the Chancellor or the Secretary of State for Health. While the Committee welcomes the closure of this loophole, it considers it unacceptable that in several cases hitherto the payment of public money in settlement of claims against NHS bodies has been made outside normal approval procedures intended to safeguard public money.

Establishing a culture which is comfortable with challenge

Responsibility for establishing a truly open managerial and professional culture which would make the role of the whistleblower redundant lies with each Trust Board. Commissioners also have a responsibility to ensure that providers to operate an open culture: without this culture it is impossible for commissioners to discharge their obligations. The CQC also has a role in working with commissioners to set challenging benchmarks for cultural norms for providers.

The Committee welcomes the CQC's new proposed approach to inspecting provider leadership, governance and culture, areas which the CQC believes "make the difference between success and failure". The CQC should, as part of its inspection regime, satisfy itself that the provider inspected has arrangements to protect and facilitate the position of any member of staff who wishes to raise concerns about the quality of patient care.

Fundamental standards of healthcare and patient safety

The Committee agrees with Robert Francis that clear and unambiguous fundamental standards of care should be established in such a way that patients, relatives, clinical and auxiliary staff and managers can immediately recognise unacceptable care and take appropriate action to remedy a breach. Any breach should be treated seriously and investigated thoroughly, but regulatory consequences should be proportionate and focus on analysis and remedy of the circumstances which have led to the breach.

Where breaches of these standards risk harm to patients, or lead to death or serious injury, the Committee considers that the breach should be treated as a criminal matter. The Committee notes the recommendation of the Berwick Review that an offence of wilful neglect or mistreatment, applicable to organisations and to individuals, should be introduced, but recommends that the Government examine how such behaviour could be prosecuted under existing offences.

The Committee is concerned by the evidence of serious failures in care for dying patients brought to light not only in Robert Francis' inquiries but also in the recent Neuberger Review of the Liverpool Care Pathway. However, the advances in quality end of life care made under the pathway approach should not be lost. The CQC should establish specific standards for end of life care to ensure that dying patients receive all the care they need to minimise any suffering.

The Committee is concerned that leadership on patient safety policy now resides with NHS England, which commissions the outsourcing of the National Reporting and Learning System (NRLS) database of patient safety incidents previously maintained by the National Patient Safety Agency. The impression given is that the overall significance of patient safety policy has been downgraded and that the effectiveness of the function has been compromised. The Committee repeats its recommendation that monitoring of patient safety practice and data should be a core responsibility of the CQC, not NHS England, and recommends that the scope of NRLS definitions of patient safety incidents be extended to cover private healthcare and taxpayer-funded social care.

Feedback and complaints

Robert Francis recognised that proper complaint handling was vital if NHS organisations were to ensure that services were to change for the better. The Government awaits the outcome of the review of complaint handling in the NHS being undertaken by Rt Hon Ann Clwyd MP and Professor Tricia Hart. The Committee takes very seriously the warning by Robert Francis that patients in a vulnerable position in hospital may not complain about poor care for fear of adverse consequences, and considers that providers should be alert to this possibility.

Staffing ratios and patient care

Robert Francis considered that evidence-based tools were required to ensure that hospital management could ensure that on any given day a provider had an adequate number of staff to treat the patient load. While he did not endorse fixed staff-to-patient ratios, he recommended that Trust boards should have a means of knowing whether each ward was adequately staffed: this would be one means of ensuring that fundamental standards were observed.

The Secretary of State has argued that evidence-based guidance on minimum staffing levels, which providers would be expected to respect, should be developed. The Committee believes that this approach will only win public confidence if providers also make a clear commitment to open and public accountability for their staffing records. Ensuring adequate staffing levels cannot be done through periodic inspection or twice-yearly reporting of staffing data, as the Government proposes. Commissioners should require all their providers to collect information on staffing at ward level on a daily basis and make it available immediately for publication in a standard format which will allow ready monitoring and comparison against benchmarks. The Committee commends the approach to staffing management and data publication taken by the Salford Royal NHS Foundation Trust.

Training and status of nurses

The Committee has noted the scepticism about the Government's proposal that every student seeking NHS funding for a nursing degree should be required to serve for up to a year as a healthcare assistant as part of a nurse training programme. The Committee is concerned that the maximum period proposed may be too long and may deter potential recruits: for this reason it recommends that the proposal should be fully piloted and carefully evaluated to determine the optimum maximum length of time for such placements. It is important that other lifetime experiences of potential trainees, including lived experience and voluntary work, are taken into account under this approach.

The Government rejected the proposal by Robert Francis for the establishment of a new category of nurse—the registered older person's nurse—to recognise the acquisition of specific skills in caring for the elderly. While the Government is concerned that introducing such a designation might risk putting older persons' nursing in a silo, the Committee considers that encouraging nurses to develop specialist skills required to care for the elderly is necessary and welcome. It recommends that the acquisition of skills in older persons' nursing should be recognised and certified, and that nurses should hold the status of registered older person's nurse in tandem with other registrations.

Training and regulation of healthcare assistants

The Committee has in the past supported the development of a registration process for healthcare assistants to be undertaken by the Nursing and Midwifery Council once its performance of its current core functions has demonstrably improved. Robert Francis also recommended the establishment of a registration and regulatory regime for healthcare assistants, together with a code of conduct and national training standards to apply to them. While training standards and a code of conduct for healthcare assistants have been

introduced, and the Professional Standards Authority is to oversee proposals for voluntary registration, the Government has ruled out proposals for compulsory registration and instead proposes to operate a vetting and barring scheme to prevent unsuitable persons from working as healthcare assistants. The Committee recognises the valuable role played by healthcare assistants and endorses proposals to encourage and support them in continuing professional development. It does not believe that the current unregistered status of healthcare assistants should continue, though it recognises that the performance of the NMC should improve before it is asked to take on additional responsibilities for registration.

Future regulation

The Government rejected the proposal of Robert Francis to establish one regulator to examine the performance of providers in terms of both quality and finance, functions undertaken by the CQC and by Monitor respectively. Instead, it has proposed a 'single failure regime' whereby the CQC, Monitor and the NHS Trust Development Authority will work with each other and with commissioners to regulate care quality and financial performance in Trusts.

The Committee is sceptical that the proposed failure regime, which is complex, can effectively address and remedy issues of care quality and financial performance in providers without considerable oversight. The Committee does not recommend any further major institutional change in the relationship between Monitor and the CQC, and proposes to examine the effectiveness of future regulatory arrangements through its programme of accountability hearings.

The Committee is concerned that much of the detail of the operation of the single failure regime will be implemented through secondary legislation, and recommends that before presentation to Parliament a draft of the relevant instruments should be published for scrutiny and comment.

The CQC has proposed that in future the frequency of hospital inspections should be risk-adjusted according to the hospital's rating, with 'outstanding' hospitals inspected once every three to five years and inadequate hospitals inspected as and when needed. The Committee considers that these proposals should be applied based on evidence and experience, and is not convinced that there is sufficient evidence or experience of the proposed process. The Committee therefore recommends the introduction of effective monitoring arrangements which can trigger an immediate inspection in cases where standards are alleged to be falling.

The Committee looks forward to examining the CQC on developments in hospital inspection at its next accountability hearing later in 2013. The Committee will wish to be assured that the inspectorate function is sufficiently well funded and resourced to meet the objectives set for it. The Chief Inspector is expected to be a champion for openness and transparency across the NHS, and the Committee expects him to inspect and report on the culture encountered in providers.

Death certification

The Committee is disappointed to learn that reforms to death certification which were recommended in 2003 as a result of the Smith Inquiry into the activities of Harold Shipman, and enacted in 2009, have not yet been brought into force. The Health and Social Care Act 2012 has passed responsibility for the new medical examiner system to local authorities, and it is understood that there have been difficulties in agreeing the charging regime to be put in place to fund the system. The Committee regrets that the implementation of the new system has been delayed until October 2014 and urges the Government to ensure that the timetable for this necessary reform does not slip further.

Robert Francis made a number of recommendations for the reform of the system of death certification, including the imposition of a duty of candour which providers should owe to coroners about the circumstances in which hospital patients have died, and a requirement that a consultant in charge of the treatment of a patient who dies in hospital should be personally responsible for certifying the cause of death. The Committee recommends that the Government give early effect to these measures, particularly those which do not rely on the implementation of the new independent medical examiner system.

1 Introduction

The Francis Report and its significance

1. The failings at Stafford General Hospital first made public in the report of the Healthcare Commission in March 2009 have cast a shadow over the reputation of the NHS for safe, high-quality patient care. So significant were the failings in the Trust, and in the broader healthcare management system supporting it, which were revealed in subsequent inquiries that in February 2013 the Prime Minister made a public apology on the floor of the House of Commons in response to the publication of the report of the Public Inquiry into the Mid Staffordshire NHS Foundation Trust.²

2. The facts of the significant failure at Stafford, as initially audited by the Healthcare Commission and given prominence by the campaign group Cure the NHS, have underlain the debate over safety and quality in the NHS for several years. The findings of the Healthcare Commission's investigation and of the reviews into the Mid Staffordshire NHS Foundation Trust undertaken for the Department of Health by Professor George Alberti and Dr David Colin-Thomé were available to the predecessor Committee when it inquired into patient safety in 2009.³ Since then, two inquiries, both chaired by Robert Francis QC, have examined the particular failings at Stafford Hospital and the more general inadequacies in the healthcare system which allowed the poor care at Stafford to persist for so long. The evidence taken in the course of both Francis inquiries—particularly the shocking experiences of poor care related by patients and relatives—informed two substantial and important reports which have provided compelling analyses of what went so badly wrong in a system supposedly geared to promoting excellence in healthcare.

3. In the report of the second inquiry into Mid Staffordshire NHS Foundation Trust, a public inquiry held under the provisions of the Inquiries Act 2005, Robert Francis has anatomised the operation of the NHS system and the interrelationships of the various bodies—Trust Board, regional health authority, Government department, regulators and others—entrusted with the responsibility of operating a safe and high quality healthcare system.⁴ In doing so he has indicated key components of a prevailing culture at Mid Staffs which he characterises as 'doing the system's business': by definition, this was a culture which tended to prioritise the smooth operation of the healthcare system above the safe and effective care of patients.

4. The importance of Robert Francis' report lies not only in its meticulous analysis of the system, identifying areas where misplaced assumptions, perverse incentives and the pursuit of natural human instincts inhibited the ability of the system to deliver high quality care, but also in its description of a culture where the most shocking and obvious deficiencies in care were apparently allowed to persist unchecked, with consequences for patients and relatives which were completely unacceptable. It is vital

2 HC Deb, 6 February 2013, columns 279–83

3 Sixth Report of the Health Committee, Session 2008–09, *Patient Safety*, HC (2008–09) 151

4 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, HC (2012–13) 898 I-III (report) and HC (2012–13) 947 (executive summary) (hence *Francis Report*)

that the pervasiveness of this culture in many parts of the health and care system is recognised.

5. The Francis report commands such attention, over four years after the initial Healthcare Commission report, because it describes a system where such lapses from basic standards appear still to be possible, and because there are so few guarantees that elements of the failings at Mid Staffs could not be repeated in other hospitals. **Robert Francis has described a healthcare system established for the public benefit and funded from public funds which now risks an undermining of public confidence in its guarantees of safety and quality.**

6. **The Committee is in no doubt as to the importance of the failures at Mid Staffs. It is vital to the interests of patients that the lessons from these failures are learned and acted upon, so that all patients can have confidence in the quality of care in the NHS. Without in any way detracting from the importance of this process, the Committee also believes that it is important to recognise that the experience of those patients at Mid Staffs who experienced poor care is not the day-to-day experience of millions of NHS patients treated each year by caring, experienced and committed staff. The purpose of highlighting the key lessons of the Francis Inquiry is not to undermine the NHS but to improve it.**

The Francis recommendations and subsequent reviews and responses

7. Robert Francis' report makes 290 recommendations for change in the health and care system, though, in truth, all can be summed up in one single recommendation—that the culture of the NHS must change in order for the safety and quality of the service, and the public's confidence in it, to improve. Robert Francis indicated that he was anxious that the report and its recommendations should stimulate real and lasting change. The Committee is similarly concerned that the inquiry process, harrowing for the patients and relatives involved and traumatic for conscientious public servants in the NHS, should lead to a lasting and positive change in culture.

8. The Prime Minister announced a number of headline measures in response to the Francis Report on the day of publication, and the Government subsequently issued what the Secretary of State described as a substantive response on 23 April 2013, which set out a more detailed response to certain areas in which Francis made recommendations.⁵ The Committee has taken account in this report the proposals in the initial Government response, including the proposals for legislation in the Care Bill [*Lords*] and the proposals for a new inspection framework published by the Care Quality Commission. A further Government response, containing a detailed response to each Francis recommendation, is expected later in the autumn of 2013. This response is to be informed by the findings of four reviews commissioned by the Government to examine areas of concern to Francis. Three of these were issued after the Committee had concluded taking evidence in its inquiry and a fourth has yet to be issued:

5 *Patients First and Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry*, Cm 8576, March 2013

- A review of the training and support of healthcare and care assistants, undertaken by Camilla Cavendish: the report of this review was published on 10 July 2013.⁶
- A review of safety practices in the 14 NHS Trusts and Foundation Trusts which have been outliers for the last two years on either or both of the recognised mortality indicators,⁷ undertaken by the NHS Medical Director, Professor Sir Bruce Keogh: the report of this review was published on 16 July 2013 and the Secretary of State made a statement to the House on its findings the same day.⁸
- A patient safety review undertaken by a National Advisory Group on the Safety of Patients in England, chaired by Professor Don Berwick: the report of this review was published on 6 August 2013.⁹
- A review of NHS complaints handling, undertaken by Rt Hon Ann Clwyd MP and Professor Tricia Hart: this review has yet to report.

9. In addition, the report of an independent review of the Liverpool Care Pathway commissioned by the Minister of State, Department of Health in January 2013 and undertaken by a team led by Baroness Neuberger was published on 15 July 2013.¹⁰ While this review was not commissioned in direct response to the findings of the second public inquiry into Mid Staffs, it followed a number of stories about complaints of poor and insensitive care and communication which “appeared to have much in common” with the complaints which prompted the Mid Staffs inquiries.¹¹ In response to the review the Minister of State for Care Services, Norman Lamb MP, announced on the same date that the Government’s intention is for the Liverpool Care Pathway to be phased out “over the next six to 12 months”, to be replaced by “an individual approach to end of life care for each patient”.¹²

10. This report gives the Committee’s view on the issues raised by Robert Francis’ report and the Government’s initial response, on which it has taken evidence, together with relevant issues thus far raised in the subsequent responses and reviews. The Committee plans to keep the Government’s response to the full set of Francis recommendations under review in the course of its ongoing programme of scrutiny.

6 *The Cavendish review: an independent review into healthcare assistants and support workers in the NHS and social care settings*, July 2013

7 The Standardised Hospital-Level Mortality Index (SHMI) or the Hospital Standardised Mortality Ratio (HSMR).

8 NHS England, *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*, 16 July 2013; HC Deb, 16 July 2013, columns 926–29.

9 National Advisory Group on the Safety of Patients in England, *A promise to learn – a commitment to act: Improving the Safety of Patients in England*, August 2013

10 Independent Review of the Liverpool Care pathway, *More care, less pathway: a review of the Liverpool Care Pathway*, July 2013; HC Deb, 15 July 2013, columns 62–64WS.

11 *Ibid*, p. 3

12 *Ibid*, columns 62–64WS

The Committee's inquiry

11. Robert Francis published the report of the public inquiry on 6 February 2013 and gave evidence to the Committee on its findings on 12 February 2013. The report consisted of three volumes, plus an executive summary, and contained 290 recommendations. The Government published its initial response to the report on 23 March 2013 and the Secretary of State made an oral statement to the House on the report the same day. Subsequently the Secretary of State appeared before the Committee on 23 April 2013 to discuss the report and the Government's response to its recommendations made to date. The Committee also took oral evidence from Sir David Nicholson KCB CBE, Professor Sir Bruce Keogh KBE and Liz Redfern CBE, representing the NHS Commissioning Board (now known as NHS England).

12. Following allegations made shortly after the report's publication that a Trust was seeking to prevent a former employee from discussing in public issues relating to patient safety at that Trust, the Committee invited Mr Gary Walker and Mr David Bowles, respectively the former Chief Executive and Chairman of United Lincolnshire Hospitals NHS Trust, to give evidence on the actions of NHS bodies which they considered had been designed to prevent Mr Walker, or had had the effect of preventing Mr Walker, from discussing in public issues of patient safety.

13. The relevant sections of this report are intended to inform debate on the clauses in Part 2 of the Care Bill [*Lords*] which make provision to change the structure of quality and safety regulation for care providers. **The Committee recommends that the Government should provide a response to the Committee's report in good time for it to be taken into account in the Second Reading debate in the Commons on the Care Bill [*Lords*].**

Parliamentary oversight of professional regulation

14. Robert Francis recommended that the Committee, through its arrangements for regular accountability hearings with professional and system regulators and otherwise, should monitor the implementation of his recommendations and the development of the cultural change in the NHS which he considers vital. **The Committee agrees with Robert Francis' recommendation for its role in monitoring implementation of his recommendations. The Committee therefore proposes to enhance its scrutiny of regulation of healthcare professionals by taking public evidence each year from the Professional Standards Authority for Health and Social Care (the PSA, formerly the Council for Healthcare Regulatory Excellence) on the regulatory environment and the performance of each professional regulator, based on the PSA's own annual report.** The Committee held an initial evidence session on 9 July with representatives of the PSA to examine its annual report and performance review for 2012–13.¹³

15. **The Committee plans to draw on the views expressed by the PSA in its reports and in these sessions in preparing for its regular accountability hearings with the General Medical Council and the Nursing and Midwifery Council. It will also examine the case for inviting other professional regulators under the PSA's remit to appear before it**

13 Oral evidence taken before the Health Committee, *Professional Standards Authority for Health and Social Care*, 9 July 2013, HC 528

from time to time, in the light of the views expressed about their performance by the PSA.

16. The Francis Report demonstrated that failure of professional responsibility was a key factor which contributed to failures of care at the Mid Staffordshire NHS Trust. The Committee has also consistently emphasised the importance of an open and accountable professional culture in its own reports during this Parliament. It welcomes Robert Francis' recommendation that there should be enhanced parliamentary oversight of the quality of professional regulation, and it intends to develop its relationship with the PSA to make this oversight as effective as possible.

2 An open and transparent NHS

Open culture and professional responsibility

17. Healthcare professionals have an unambiguous professional duty to raise with the relevant authorities any concerns which they may have about the safety and quality of care being delivered to patients. Managers do not operate within the same framework of regulated professional obligations but they should also be expected to raise concerns about matters affecting patient safety and care quality and to be able to do so openly and without suffering personal detriment.

18. The Committee believes that Trusts and other care providers have a fundamental duty to establish an environment where concerns about patient safety and care quality raised by clinicians or managers are addressed openly and directly.

19. Robert Francis told the Committee that an essential element of the recommendations in his report was that “there should be no obstruction to individuals, or groups of individuals, raising honestly-held concerns about patient safety”:

They need to be listened to. If there is to be a penalty, it should be to penalise those who do not exercise their responsibility to raise those things, not the other way around.¹⁴

He went on to say that

There needs to be full protection for people who genuinely raise concerns rather than the extremely complex system we have at the moment. If we did that, we would not have to be talking about whistleblowers. We could talk about everybody contributing to a safe system and being welcomed for so doing.¹⁵

The principal changes necessary to establish a genuinely open culture are discussed below.

20. Robert Francis told the Committee that his recommendations came as a package, which had five principal themes. One of these was the promotion of openness, transparency and candour, not just in relation to individual incidents of harm but in more general terms:

That is a package. It is about candour to patients, but it is also about honesty with the public, commissioners and regulators.¹⁶

[T]here is a little bit of confusion often in what we mean by a duty of candour. Conventionally, the discussion has been in terms of candour about honesty to the patient, in telling a patient who has been harmed or might have been harmed by care the truth about that. There is a wider field of candour, which I distinguish by calling

14 Q34

15 *Ibid.*

16 Q85

it “openness and transparency”, which is about the truth as to more general information concerning the service.¹⁷

21. The Committee agrees with Robert Francis that the key requirement is for a culture change within the NHS which values openness and transparency in all care delivery—not just when things go wrong. The duty of candour does not simply arise in cases of service failure; the requirement for an open culture which encourages challenge is fundamental to the delivery of high quality care.

The existing duty and practice of candour in the NHS

22. During the course of the Committee’s 2011 inquiry into complaints and litigation, the Government announced that it would introduce a new requirement on NHS providers, in their contracts with commissioners, to be open and transparent in admitting mistakes in their care. NHS England (the NHS Commissioning Board) has introduced a contractual duty of candour as one of the service conditions of the NHS standard contract for 2013/14.¹⁸

23. The new duty in the standard contract applies to patient safety incidents which result in moderate harm, severe harm or death (using the definitions provided by the National Patient Safety Agency) and which are reported to local management systems. While the contractual duty does not apply to incidents which result in low or no harm, guidance to providers requires these incidents to be reported to the patient where appropriate.¹⁹ Under the terms of the contract, the patient (or relative or carer) must be informed of a suspected or actual patient safety incident within at the most 10 working days of the report of the incident to local systems.

24. The terms and definitions for grading patient safety incidents established by the National Learning and Reporting System of the National Patient Safety Agency are set out in Table 1. The Committee comments further on the scope of application of these terms and definitions at paragraph 133 below.

25. The initial notification must be delivered verbally, and face to face where possible, accompanied by the offer of a written notification, and recorded for audit. An apology, both verbally and in writing, must be provided: guidance to providers makes clear that a sincere apology expressing regret for harm caused is not tantamount to an admission of liability, and the risk of litigation should not prevent an apology.

17 Q36

18 Service Condition (SC) 35. The standard contract is available at <http://www.england.nhs.uk/wp-content/uploads/2013/03/contract-service.pdf>

19 NHS Commissioning Board, *2013/14 NHS Standard Contract: technical contract guidance*, 4 February 2013, available at <http://www.england.nhs.uk/wp-content/uploads/2013/02/contract-tech-guide.pdf>

Table 1: National Reporting and Learning System terms and definitions for grading patient safety incidents

Grade of patient safety incident	Definition
No harm	<p><i>Incident prevented</i> – any patient safety incident that had the potential to cause harm but was prevented, and no harm was caused to patients receiving NHS-funded care.</p> <p><i>Incident not prevented</i> – any patient safety incident that occurred but no harm was caused to patients receiving NHS-funded care.</p>
Low harm	<p>Any patient safety incident that required extra observation or minor treatment and caused minimal harm to one or more patients receiving NHS-funded care.</p> <p><i>Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned; nor does it include a return to surgery or readmission.</i></p>
Moderate harm	<p>Any patient safety incident that resulted in a moderate increase in treatment and that caused significant but not permanent harm to one or more patients receiving NHS-funded care.</p> <p><i>Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or, as an outpatient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident.</i></p>
Severe harm	<p>Any patient safety incident that appears to have resulted in permanent harm to one or more patients receiving NHS-funded care.</p> <p><i>Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.</i></p>
Death	<p>Any patient safety incident that directly resulted in the death of one or more patients receiving NHS-funded care.</p> <p><i>The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.</i></p>

Being open: Communicating patient safety incidents with patients, their families and carers, National Patient Safety Agency National Reporting and Learning Service, November 2009, Appendix B

26. Incident investigation reports must be shared with the provider's Board or medical director and the appropriate commissioner promptly following completion of any investigation. Providers are required to inform the patient's commissioner when they are communicating with a patient (or relative or carer) about an incident, though this requirement may be fulfilled by six-monthly reports as part of contract review.²⁰

27. If an incident is not reported, but subsequently comes to the attention of a commissioner, the commissioner is required to raise the matter with the provider: if an incident has not been reported to the patient or to local systems, the breach of contract should be treated very seriously: where serious injury or death has ensued, commissioners

should consider reporting to the CQC the provider's failure to notify as a breach of the provider's registration requirements.²¹

28. The consequences of the breach of the contractual duty are set out in the contract, and include the commissioner requiring the chief executive to provide a direct written apology and explanation to the individual or individuals affected, the commissioner requiring the provider to publish notification of the breach on its website, or the commissioner notifying the CQC. Commissioners may also recover the cost of the episode of care (or £10,000, where the cost of the episode is unknown) from the provider.²²

29. The principles now set out in the NHS standard contract with regard to candour with patients are sound, but experience in Mid Staffs and elsewhere makes it clear that such principles have in the past been too often honoured in the breach rather than in the observance. Whatever additional safeguards may be introduced, the Committee regards the enforcement of these principles on all providers of NHS services as a fundamental part of the role of NHS commissioners. Failure to apply to these principles in practice should be seen as a failure of enforcement by commissioners as well as a failure of performance by service providers.

30. Furthermore, the Committee believes that in the requirement for openness and transparency is too narrowly drawn in the NHS Standard Contract. The requirement for candour about mistakes should, in truth, be seen as part of a much wider commitment an open and accountable service. Challenge and debate about outcomes should occur at all levels of quality achievement and in all contexts of care, not just at the bottom. Indeed the Committee believes that if high quality service providers were to set the pace for openness and transparency by making properly anonymised information available on a dramatically improved basis, they would increase the pressure on less good providers to demonstrate that they were matching their standards to the best. Verbal commitments to high quality standards are virtually meaningless if no effective steps are taken to monitor performance.

Accountability of commissioners

31. In addition to its support for the role of commissioners in enforcing a new culture of openness on providers, the Committee also recommended in its 2011 report on *Complaints and Litigation* that the NHS Commissioning Board should, when authorising commissioning bodies, place the commissioners themselves under a contractual duty of candour to their populations and to their local HealthWatch organisations.²³ In response, the Government indicated that it would consult on "the expectations which should be placed on commissioners in terms of publicly reporting how often they are made aware of instances of non-disclosure and what action they have taken as a result."²⁴

21 *Ibid.*

22 *Ibid.*

23 Health Committee, Sixth Report of Session 2010–12, *Complaints and Litigation*, HC 786-I, para 82

24 *Government Response to the House of Commons Health Select Committee Sixth Report of Session 2010–11: Complaints and Litigation*, Cm 8180, para 73

32. In the event NHS England has not placed commissioners under any explicit duty of candour either to local populations or to local HealthWatch organisations. In the Committee's view, such a duty is vital to build public confidence in the commissioning system and to ensure that communities can hold their commissioners of health and care services fully to account for the public money spent and the services commissioned. An effective duty of candour on commissioners would also reinforce the requirement for commissioners to enforce the principles of openness which are set out in the NHS standard contract between commissioners and providers. **The Committee continues to believe that commissioners should be under an obligation to collect and publish full information about outcomes achieved for their communities, including a full account of failures to deliver acceptable standards of care. By failing to apply a duty of candour explicitly to commissioners, NHS England is losing an important opportunity to promote a more open and accountable culture throughout the NHS.**

The NHS Constitution

33. The contractual duty of candour between provider and commissioner, which is accompanied by a revised pledge to patients in the NHS Constitution: the previous pledge

that when mistakes happen, to apologise, explain what went wrong and put things right quickly and effectively

has been superseded by the pledge

to ensure that when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again.

34. The Government explains that this new pledge reflects the introduction of the contractual duty of candour, and is more specific in acknowledging where mistakes in care have been made.

35. **The Committee believes that the new formulation in the NHS Constitution explaining the duty of candour substantially understates the importance of a more open culture in the NHS. Commissioners and providers should be under a duty of openness about the full range of outcomes achieved, not just about examples of patient harm. More open accountability for outcomes achieved would be an important spur to improvements in the quality of care delivered across the full range of health and care facilities. It must be driven from NHS England, but it must permeate every aspect of care provision. It is the role of commissioners to ensure that the providers of NHS care provide timely, accurate and complete information to both individual patients and commissioners.**

The Francis recommendations

36. Robert Francis found that current requirements in the NHS “do not cover uniformly and consistently the areas in which [openness, transparency and candour] are needed.” He recommended that the following principles should underpin future requirements for openness, transparency and candour in the NHS:

- Every healthcare organisation and everyone working for them, or on their behalf, must be honest, open and truthful in all their dealings with patients and the public.
- Organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.
- Where harm has been, or may have been, caused to a patient by an act or omission of the organisation or its staff, the patient (or, if the patient is deceased, any lawfully entitled personal representative) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support.
- Full and truthful answers must be given to any question reasonably asked by a patient (or, if deceased, by any lawfully entitled personal representative) about his or her past or intended treatment.
- Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.
- Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.²⁵

In applying these principles Mr Francis made three recommendations to amend the legal obligations on providers of healthcare.

37. Mr Francis’ first recommendation is that a statutory obligation to observe a duty of candour should be imposed:

- i. on healthcare providers “who believe or suspect that treatment or care provided by [the provider] to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request”; and
- ii. on registered medical practitioners and registered nurses and other registered professionals “who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable”.

The provision of information in compliance with this requirement “should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy”.²⁶

38. Secondly, Mr Francis recommended that there should be a statutory duty “on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation on the organisation to provide it.”²⁷

39. Thirdly, Mr Francis recommended that “it should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation:

- Knowingly to obstruct another in the performance of these statutory duties;
- To provide information to a patient or nearest relative intending to mislead them about such an incident;
- Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.”²⁸

Observance of the duty “should be policed by the Care Quality Commission, which should have powers in the last resort to prosecute in cases of serial non-compliance or serious and wilful deception. The Care Quality Commission should be supported by monitoring undertaken by commissioners and others.”²⁹

The case for a statutory duty

40. In evidence to us, Robert Francis clarified that his requirement for a statutory duty of candour filled a gap in the obligations of NHS organisations to be honest with patients:

In relation to candour to the patient we already have a professional obligation, in their codes of conduct, on the part of doctors and nurses to be honest with patients. What we lack, except by means of guidance, is an obligation on the part of organisations to be honest with patients. First, the organisation must have that responsibility, and, in practical terms, it is the organisation that needs to organise the telling of the patients quite a lot of the time.³⁰

A statutory duty was required as a means to, and a precondition of, the substantial change in culture which was required across the NHS. He put it in these terms:

What we have to do is to find a means of making it the normal thing to do to raise concerns about what is going on in the hospital and, if necessary, about colleagues.

26 *Francis Report*, recommendation 181, chapter 22

27 *Francis Report*, recommendation 182, chapter 22

28 *Francis Report*, recommendation 183, chapter 22

29 *Francis Report*, recommendation 184, chapter 22

30 Q36

The way you do that is by making it more difficult not to do that than it is to do it. I know that sounds slightly counterintuitive, but we need encouragement, I am afraid, for people to take their courage and to make it their obligation so that they have at least the protection, and can say to their colleague, “I am frightfully sorry but I had to do this because if I didn't I could be prosecuted.”³¹ That is a pretty good start when talking to your colleagues. I believe, although it may, when you first think about it, sound paradoxical, that it will encourage openness as the norm at a stage before you need to talk about whistleblowers.

He considered that the contractual duty of candour owed by a provider to a commissioner did not go far enough:

The reason I think it should be a statutory duty is that it is all very well having a contractual obligation to a commissioner, but the reality is that the obligation is to the patient. There needs to be that direct relationship, which needs to be recognised and [. . .] it follows that there will be a remedy involved if that was breached in itself. So there is that duty enforced by a sanction, which means that anyone who gets in the way of that duty deliberately should be subject to criminal sanction.³²

By way of illustration, he referred to a case which had come to light during the inquiry where a consultant's report relevant to the death of a patient consequent on treatment at Stafford General Hospital had been withheld from a coroner's inquest, and from the family, on the basis of legal advice given by the Mid Staffordshire Trust's legal department “because it was believed—honestly believed—by those doing it that it was in the trust's best interests to do that, which is, I am afraid, not a happy story for my profession.”³³

41. This case was discussed at length in Robert Francis' report.³⁴ Mr Francis criticised the Mid Staffordshire Trust over the failure to disclose to a coroner material which might have been of assistance to him, and concluded that in such circumstances the primary consideration for a Trust's solicitors should be “whether the information in the solicitor's possession would, or could, reasonably be considered to be of assistance to the Coroner, whether or not it showed the trust in a poor light.”³⁵ In the case in question, Mr Francis concluded that “the only possible answer” was that the material should have been disclosed. The trust and confidence of the bereaved family in the Trust had been seriously damaged by the concealment of the report: that concealment “caused more distress than disclosure could ever have done”.³⁶

42. Mr Francis observed that existing guidance requiring trusts and clinicians to be open with patients and bereaved families about adverse incidents, and to offer them full explanations of what occurred, “should be a very significant factor to be taken into account

31 Mr Francis clarified that the situation might equally apply to professionals who might otherwise be subject to disciplinary sanction by their professional bodies.

32 *Ibid.*

33 *Ibid.*

34 *Francis Report*, paras 2.164 – 2.210: the case in question is the death of John Moore-Robinson.

35 *Ibid.*, para 2.204

36 *Ibid.*, para 2.209

in deciding where the interests of a trust lie”.³⁷ The inquiry had heard that there was no duty in law—either in statute or in common law—for those in possession of factual information concerning a death to volunteer such information to a coroner, and he therefore concluded that many other solicitors acting for and advising Trusts would have acted no differently. He therefore believed that there was

an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.³⁸

43. Mr Francis was also critical of the way the Trust had behaved in its response to a civil claim made against the Trust by the bereaved family. The way the Trust had conducted the litigation had revealed “some unfortunate characteristics all too common in clinical negligence claims”.³⁹ A written apology sent to the family by the Trust Chair, in which the hope was expressed that a swift settlement would enable the family “to put this matter behind you and move on”,⁴⁰ was described as “formulaic, insensitive, patronising and likely to exacerbate wounds rather than heal them”.⁴¹ The Trust appeared to have conceded internally that the claim was indefensible and that it would be reasonable for the Trust to settle, and did not seek evidence to the contrary: yet it persisted in denying liability in an attempt to negotiate a lower settlement, a position “entirely inconsistent with the professed policies and guidance calling for openness and transparency about adverse incidents”.⁴² Despite complaints of the bereaved family about the way the settlement had been handled, the Trust’s solicitor maintained that the settlement had been a success.⁴³

44. The Committee believes that a defensive and sometimes over-legalistic culture which attaches a higher priority to avoiding liability than improving outcomes represents a pervasive phenomenon which is not confined to the healthcare system. While legal accountability is important, it is even more important that legal advice based on such defensive considerations is not allowed to impede the proper relationship between clinical professional and patient, based on sound principles of professional responsibility.

45. Similarly, defensive and over-legalistic considerations of the best interests of Trusts should not be allowed to override the duty to be open and transparent with patients and relatives about adverse incidents, and to provide to them full explanations of the factors which led to such incidents. It is particularly important that NHS bodies provide full and candid explanations to relatives bereaved as a result of an adverse incident.

37 *Ibid.*, para 2.204

38 *Ibid.*, para 2.206

39 *Ibid.*, para 2.210

40 *Ibid.*, para 2.186

41 *Ibid.*, para 2.210

42 *Ibid.*

43 *Ibid.*

46. The Committee discussed with Mr Francis the potential difficulties which a statutory duty of candour might pose for medical professionals and others involved in patient safety incidents, where it appeared that a requirement to be open and honest about any mistakes made might conflict with legal advice from a provider, with an eye to admissions of liability, about what admissions should or should not be made.

47. While Mr Francis recognised that medical professionals required to be open and honest about errors might, in admitting mistakes, open themselves to the possibility of professional misconduct proceedings, he thought that professional regulators would be far more lenient on those who owned up to errors with a serious effect on patient safety than they would on those who denied or sought to cover up their lapses:

We need a situation where the legal advice is going to be, “I know this is unfortunate, but you are going to be better off by telling them about it and being honest and open about it than not.”⁴⁴

Reactions to the Francis recommendations

48. In its response to Francis, the Government has indicated that it will consider a statutory duty of candour on providers to inform patients or relatives of cases where the provider believes that treatment or care has caused death or serious injury, and to explain why. The scope of the duty is to be “carefully considered”.⁴⁵ The Secretary of State told the Committee that “we think that providers should have a duty in law to be transparent with people when they have done harm, and we accept that.”⁴⁶

49. The Government has since indicated that the statutory duty of candour will be introduced as a requirement on providers registered with the Care Quality Commission, and that provision for the statutory duty will be made through secondary legislation rather than on the face of the Care Bill [*Lords*].⁴⁷

50. The report of the Berwick Review of patient safety in England also recommended a statutory duty of candour: “where an incident qualifying as a Serious Incident (as defined by NHS England) occurs, CQC regulations should require that the patient or carers affected by the incident be notified and supported.”⁴⁸

51. Berwick also, however, enters some important caveats about the scope of a statutory duty, and indeed about the scope of the contractual duty in the NHS Standard Contract. The Berwick Review eschews “an automatic ‘duty of candour’ where patients are told about every error or near miss, as this will lead to defensive documentation and large bureaucratic overhead that distracts from patient care”. Berwick does recommend that “patients should be given all the information they ask for” and suggests the commissioning of research “to study how proactive disclosure of serious incidents, and the process of engaging with patients in relation to less serious incidents, can best be supported.”

44 Q45

45 *Patients First and Foremost*, Cm 8576, para 2.31

46 Q496

47 HL Deb, 20 June 2013, column 398 [Earl Howe].

48 *A promise to learn – a commitment to act*, p. 34

52. The Government plans to work with professional regulators to see “what more can be done to encourage professionals to be candid with their patients at all times”.⁴⁹ This falls short of Robert Francis’ recommendation for a specific duty of candour on medical professionals to report to their employer a belief or suspicion that treatment provided to a patient has caused death or serious injury.

53. Berwick explicitly does not support the Francis recommendation of a statutory duty for healthcare workers to report beliefs or suspicions about serious incidents to employers, considering that this duty “is adequately addressed in relevant professional codes of conduct and guidance”.⁵⁰

The role of criminal sanctions for individuals and healthcare organisations

54. The Government has expressed caution about introducing criminal offences to apply to individuals working in healthcare settings, arguing that they may unintentionally introduce a “culture of fear”, preventing lessons from being learned. However the Government agrees that “robust action” should be taken in instances where staff are “obstructively dishonest”. In addition, criminal sanctions are proposed for staff who deliberately allow fundamental standards of care⁵¹ to be breached. Ministers plan to take advice from the professional regulators and to consider the findings of the Berwick Review on the appropriateness of criminal sanctions to be applied below Board level.⁵²

55. The Berwick Review expresses extreme caution about any proposal to apply criminal sanctions to individual staff working in healthcare settings. Such sanctions should only be applied in cases where individuals are demonstrably guilty of wilful or reckless neglect, and only then in accordance with several stringent criteria concerning, for example, the severity of the case and the level of culpability of the individual. The Committee addresses these matters further at paragraph 115 below.

56. Berwick does concur with Francis in recommending that leaders in healthcare organisations “who deliberately withhold information or who provide misleading information” should be subject to penalties.⁵³

57. The Government proposes that care providers who “knowingly supply wrong information” or who “deliberately withhold information from families about serious harm or death” are to be subject to additional legal sanctions at a corporate level. Provision for a new offence and for penalties have now been introduced as part of the Care Bill [*Lords*]⁵⁴:

- Clause 81 of the Bill introduces a new criminal offence, to apply to care providers as corporate bodies. Any such provider who supplies information required by

49 *Patients First and Foremost*, Cm 8576, para 2.32

50 *A promise to learn – a commitment to act*, p. 34

51 Robert Francis’s proposals for fundamental standards of care are addressed in chapter 3.

52 *Patients First and Foremost*, Cm 8576, para 2.33

53 *A promise to learn – a commitment to act*, p. 33

54 HL Bill 1 of Session 2013–14. Unless stated otherwise, all references to clauses in the Care Bill [*Lords*] are to the print of the Bill as originally introduced to the House of Lords.

statute or another legal obligation which is materially false or misleading commits an offence.⁵⁵

- Clause 82 of the Bill provides that a care provider convicted of an offence is liable to a fine on conviction, with the option for the sentencing court to impose on the provider a remedial order (requiring the provider to put right the misleading information and any materially relevant deficiency in its practices), a publicity order (requiring the provider to publicise the fact of the conviction, details of the offence and the fine imposed and details of any remedial order made), or both.⁵⁶

The Committee's view

58. In its 2011 report on *Complaints and Litigation* the Committee reached the following conclusion on the introduction of a statutory duty of candour:

The Committee does not think that placing further statutory duties on the NHS will produce the shift in culture that is required to ensure that patients get full disclosure of information when things go wrong. The emphasis on the importance of culture change [...] may have more impact than further statutory change.⁵⁷

59. The Committee is mindful that NHS history is littered with examples of well-intentioned changes which have been superimposed on existing arrangements without sufficient attention being paid to the way in which it is proposed that the new arrangements will interact with existing processes. It is striking, for example, that the clauses in the Care Bill [Lords] which are intended to establish a criminal offence of providing false and misleading information—in effect criminalising a breach of the proposed statutory duty of candour—have specified neither the types of provider, nor the types of information to which the offence will apply, leaving both to be specified later in regulations.

60. The Committee remains to be persuaded of the case for the introduction of a statutory duty in addition to existing contractual duties and professional obligations. It is not clear that the proposed duty, the terms of which remain to be defined in secondary legislation, will constitute an effective means of achieving the fundamental culture change which is required within the NHS.

61. The Committee continues to believe that it is mistake to think of the requirement for a more open culture specifically in the context of failures of care. The culture change which is required within the NHS requires greater openness across the full range of its activities—including examples of care that do not match current best practice, as well as overt failure.

55 HL Bill 1-EN, paras 425–431

56 *Ibid.*, paras 432–438

57 Health Committee, Sixth Report of Session 2010–12, *Complaints and Litigation*, HC (2010–12) 786, para 80

62. The Berwick Review recommends the commissioning of research into how best to support the proactive disclosure of serious incidents and the process of engaging with patients in relation to less serious incidents. While further research into these matters is necessary, and is likely in the medium term to make a positive contribution to candid dialogue between providers and patients, it should not delay the implementation of measures designed to entrench a culture of openness and candour across the full range of NHS activities.

3 Raising concerns and resolving disputes

The Francis Report and whistleblowers

63. The issue of whistleblowing—the disclosure, either to a person in authority or in public, of information concerning unsafe, unethical or illegal practices—was pursued at length in the public inquiry hearings. Mr Francis found that the Mid Staffs Trust had a number of whistleblowing policies in place between 2005 and 2009, all of which had “the clear objective to empower employees to raise concerns and to ensure that those concerns, where valid, were acted on. Employees raising issues were to be protected and supported, where possible, by measures including respect for confidentiality.”⁵⁸ He found that, despite the existence of such policies, no adequate support was given to one nurse, Helene Donnelly, who attempted to raise concerns about poor practice in the A&E department at Stafford General Hospital: her concerns were investigated, but the way in which the investigation was conducted gave little encouragement to other potential whistleblowers to come forward. There was scant regard for the complainant’s anonymity and no formal determination was made as to whether her allegations were accepted. She was provided with no adequate support, endured harassment from colleagues and eventually left the Trust. In her evidence to the Inquiry she observed that whistleblowing policies were fine on paper, but if not given substance in practice would not encourage others to come forward and raise concerns.⁵⁹

64. The report of the inquiry describes a culture at Mid Staffs where medical professionals felt inhibited in raising concerns for a number of reasons: they considered that such concerns would not be acted on effectively, they feared negative repercussions from colleagues or they feared victimisation by management. In one instance, where a consultant was disciplined for his behaviour towards other staff when he sought to complain about sub-standard staffing, the Inquiry was not able to confirm the charge of victimisation on the evidence before it. Nevertheless, Mr Francis observed that such sanctioning “is an example of something seen all too often in the treatment of complainants raising concerns relevant to patient safety”:

A greater priority is instinctively given by managers to issues surrounding the behaviour of the complainant, rather than the implications for patient safety raised by his complaint.⁶⁰

65. Robert Francis summed up the difficulty inherent in whistleblowing as follows:

The experiences described here do not suggest that, whatever system is in place, it will be easy for staff to raise concerns which are not accepted by those for whom they work. Theoretical protection is provided by the Public Information Disclosure Act

58 *Francis Report*, para 2.371

59 *Francis Report*, para 2.381

60 *Francis Report*, para 2.392

1998, but this is unlikely to be of much reassurance to staff who have to face the wrath of their colleagues.⁶¹

He reached the following conclusion:

. . . [W]histleblowing is only necessary because of the absence of systems and a culture accepted by all staff which positively welcomes internal reporting of concerns. If that culture is absent then raising concerns external to the system is bound to be a difficult and challenging matter exposing the whistleblower to pressure from colleagues. Therefore the solution lies in creating the right culture, not in focusing on improvements to whistleblowing legislation, important though such protection is.⁶²

66. The Committee has previously strongly supported the development of an open culture in NHS organisations to enable professional concerns to be raised with management. In its report on healthcare regulators in 2012 it said:

The Committee continues to believe that the effective exercise of professional responsibility is the bedrock on which high standards of patient care are built. It also continues to believe that there is an essential public interest in ensuring that professionals are protected against punitive action when they raise concerns about professional standards at their place of work.⁶³

67. In its initial response to the Francis Report, the Government observes that healthcare staff have professional duties and contractual rights to raise concerns where basic care standards are not being met, and claims that it has already taken a number of steps to enhance protection available to whistleblowers. Contracts of NHS staff will include a right to raise concerns; the NHS Constitution has been amended to include explicit rights and pledges on whistleblowing; fresh guidance on the subject has been issued to employers; the national whistleblowing helpline has been extended to include staff in social care settings; whistleblowing questions have also been included in the NHS Staff Survey; and an amendment to the Enterprise and Regulatory Reform Act 2013 has extended protection under the Employment Rights Act 1996 (as amended by the Public Interest Disclosure Act 1998) to all categories of NHS staff.⁶⁴ That Act has also introduced a provision aimed at preventing victimisation of whistleblowers, by extending in certain circumstances to employers the liability for detriment caused to a whistleblowing employee by a colleague.

68. The Government's actions are welcome, as far as they go, but Robert Francis suggested that a legislative solution focussed on protecting whistleblowers was missing the point:

Whatever legislation you have about whistleblowers, so-called, it will not in itself stop the sorts of things that the Stafford whistleblowers had to put up with from their colleagues, so-called, in the ward. It may help you at an employment tribunal later

61 *Ibid.*, para 2.398

62 *Ibid.*, para 2.400

63 Health Committee, Fifteenth Report of Session 2010–12, *Annual accountability hearings: responses and further issues*, HC (2010–12) 1699, para 14

64 Enterprise and Regulatory Reform Act 2013, s. 20, brought into effect on 25 June 2013

down the line, but it does not help you at the time. What we have to do is to find a means of making it the normal thing to do to raise concerns about what is going on in the hospital and, if necessary, about colleagues.⁶⁵

69. As the Committee has noted above, **Robert Francis has recommended a change in the culture whereby it is easier, and more palatable, to raise a genuine concern than it is not to do so. The Committee agrees with this approach, although it recognises that there can be serious consequences for individuals who do raise their concerns. The management of each provider of NHS care has an unequivocal obligation to establish a culture in the organisation within which issues of genuine concern can be raised freely. Disciplinary procedures, professional standards hearings and employment tribunals are not appropriate forums for constructive airings of honestly-held concerns about patient safety and care quality.**

Compromise agreements, gagging clauses and special severance payments

70. Mr Francis was sharply critical of the practice of including “gagging” clauses—more properly termed “non-disparagement” clauses—in compromise agreements between publicly-funded healthcare organisations and present or former employees.

71. It is worth setting out his findings in full:

Non-disparagement clauses are not compatible with the requirement that public service organisations in the healthcare sector, including regulators, should be open and transparent. They are to be distinguished from confidentiality clauses: there is obviously a need to preserve confidentiality in particular areas, either permanently or temporarily. Examples of this include:

- *Patient confidentiality: it is important that details capable of identifying patients and their families should not be placed in the public domain;*
- *Prevention of prejudice to investigations: it will sometimes be against the public interest for details of current investigations to be allowed into the public domain until such time as the danger of prejudice has passed. For example, it would be wrong for an intention to make an unannounced visit to be leaked to the trust to be visited;*
- *Employee confidentiality: employees may be entitled to privacy with regard to their pay and the terms of any settlement on their departure. It is less easy to envisage many cases in which the employer is entitled to confidentiality about such matters should it be waived by the employee.*

Even in areas where confidentiality is potentially justifiable, consideration will have to be given to whether there is a public interest in disclosure which outweighs the need or justification for confidentiality.

It is unjustifiable in almost all circumstances:

- *To prevent any employee or past employee making disclosure to a public authority, including a regulator, a Government department, or an inquiry, of matters internal to the organisation, which he or she honestly believes to be in the public interest to make;*
- *To prevent any past employee publishing or communicating any criticism of or adverse comment about the organisation, except to the extent that to do so would disclose information justifiably required to be held confidential.*

A clause of the type contained in the agreement with Dr Wood is an impermissible inhibition on free speech, and, just as importantly, is against the public interest in dissemination and consideration of genuinely held concerns about matters of patient safety. It is doubtful that clauses as restrictive as this are common practice in the private sector, but even if they are, the practice should cease in the public sector. Any clause restricting an individual's liberty to make a disclosure or imposing a duty of confidentiality, should be limited to the minimum necessary to protect the public interest, and not the reputation of any organisation or individual. The CQC has suggested that non-disparagement clauses of the type it has used do not, as a matter of law, prevent disclosure being made in the public interest. While, without expressing a legal opinion on the point, that may be correct, employees cannot be expected to understand this unless they are specifically informed of the exception, preferably by it being referred to in the contractual clause. In any event, such an exception is likely to cause sufficient doubt as to its meaning in the mind of an employee that further clarification of the true intended limits of a non-disparagement clause would still be required. Therefore, the recent assurance received from the CQC that it now has no intention of using such clauses again in termination agreements, unless there are exceptional circumstances, is to be welcomed as a step in the right direction.⁶⁶

Government response

72. The Government has acknowledged that confidentiality clauses may be necessary in compromise agreements, to ensure a “clean break” at the end of the employment, but stresses that such clauses should go no further than is necessary to protect patient confidentiality and the public interest: they should not seek to prevent a departing employee from making a disclosure in the public interest.⁶⁷

73. In response to concerns raised by the Committee and others by the treatment of Gary Walker, a former NHS chief executive subject to a compromise agreement with his former employer which contained a gagging clause, the Secretary of State wrote to Trusts on 15 February 2013 to remind them of their obligations to have policies compliant with the Public Interest Disclosure Act 1998 and to check that confidentiality clauses “embrace the spirit” of such obligations.⁶⁸ Trusts have also been reminded that they should insert clauses

⁶⁶ *Francis Report*, para 22.61–22.62. Dr Heather Wood led the Healthcare Commission investigation into Mid Staffs which reported in February 2009. She joined the CQC, the successor body to the Healthcare Commission, and subsequently left the employment of the CQC under a settlement governed by a compromise agreement which contained a non-disparagement clause: see *Francis Report*, para 22.54

⁶⁷ *Patients First and Foremost*, Cm 8576, para 2.36

⁶⁸ The case of Mr Walker is discussed in greater detail in the Annex.

into compromise agreements to make clear that nothing in the agreement should prevent the parties from making a protected disclosure in the public interest. The Secretary of State described his approach thus:

[. . . S]ome of the contracts that are used, and one of the clauses that has typically been in some of the compromise agreements when NHS staff have left the employment of the NHS has been a clause that prevents them from speaking out. If agreements are over a certain value, they have to be approved centrally—not by the Department of Health, but by the Treasury—and we have made it clear that we will not approve any of those contracts unless they explicitly say that people will be free to continue to speak out on matters of patient safety.⁶⁹

74. The Secretary of State also confirmed that the Department’s policy in effect had retrospective application, and that persons who were parties to agreements containing “gagging” clauses which may have inhibited them from raising concerns about patient safety should now consider themselves able to do so without fear that provisions for breach of the agreement might be enforced against them.

75. Sir David Nicholson confirmed that the scope of matters which should not be subject to a gagging clause was not narrowly defined: more general concerns about failures to meet NHS objectives in the quality of care should similarly fall outside the ambit of any gagging clause. He had concerns about restricting the ambit of such clauses further to exclude disputes with management over issues which might touch on patient safety, as “there is some kind of ring to run round it”, but he accepted that members of staff who saw things that did not “look or smell right” should have the confidence to raise them.⁷⁰

76. The Committee agrees with Robert Francis that providers of health and care, as well as their regulators, should be required to be open and transparent. Non-disparagement or ‘gagging’ clauses which inhibit free discussion of issues of care quality and patient safety are unlawful. No NHS body should be party to such an agreement or should seek to enforce an agreement in a way which inhibits free discussion of such issues.

Compromise agreements at the Care Quality Commission

77. Even before the publication of the Francis report, the Committee was sufficiently concerned by reports of the use of compromise agreements to ‘gag’ former CQC staff to write to the incoming Chair of the CQC, David Prior, to seek an assurance that confidentiality clauses would not be used to prevent staff from making disclosures in the public interest.

78. Mr Prior responded to set out the CQC’s policy on confidentiality clauses in compromise agreements. He indicated that the CQC had revised the wording of its standard compromise agreement to make it clear that such agreements did not prevent them from raising “legitimate concerns” through a protected disclosure. He considered that the current protection under the provisions of the Public Interest Disclosure Act 1998

69 Q523

70 Qq 239, 242

was sufficient to enable staff subject to existing compromise agreements to raise “legitimate concerns” that they believed to be in the public interest.⁷¹

79. The Committee welcomes the assurance from the Chair of the Care Quality Commission that its standard compromise agreement now includes a clause making it clear to employees that such agreements do not prevent them from raising legitimate concerns through protected disclosures. The Committee recommends that the CQC should write to each employee or former employee with which it has an existing compromise agreement to confirm that any non-disparagement terms of such agreements will not be enforced in cases where such persons wish to raise concerns which they believe to be in the public interest.

Compromise agreements and severance payments

80. The National Audit Office has recently reported on the arrangements followed by Departments in making severance payments related to compromise agreements. A ‘special severance payment’ over and above an employee’s contractual entitlement can be made to compensate for loss of employment, and reflects an element of risk on the employer’s part should a case be taken to an employment tribunal. The Treasury regards special severance payments as ‘novel and contentious’ and in all cases requires Departments to seek its approval before authorising them.⁷²

81. Following the appearance of Sir David Nicholson before the Committee on 4 March 2013, the Department provided information on the procedures applying to special severance payments in NHS organisations other than foundation trusts.⁷³ The Department indicated that such payments were first of all required to be authorised by the remuneration committee of the NHS body in question, and then supported by the relevant strategic health authority before approval by the Department and subsequently the Treasury.

82. Sir David Nicholson told the Committee that the authorisation of the payment in the case of Gary Walker, discussed below, had not passed through the approval process detailed above, since the settlement had been achieved through judicial mediation. He stated that the arrangement was not one he had encountered before. The Department subsequently confirmed that special severance payments made as a result of judicial mediation had not hitherto required approval from the Treasury or the Secretary of State for Health, but that with effect from 11 March 2013 approval from both would be required.⁷⁴

83. In evidence to the Public Accounts Committee on 17 June 2013 Sir David claimed that Treasury guidance in 2011 had indicated that Treasury approval was not required for payments in relation to severance or compromise agreements achieved through judicial

71 The exchange of letters is printed at Appendix 1.

72 National Audit Office, *Confidentiality clauses and special severance payments*, HC (2013–14) 130, para 1.8

73 NHS Trusts, primary care trusts, strategic health authorities and special health authorities

74 HC Deb, 12 March 2013, column 182W

mediation, though the position had now been corrected.⁷⁵ He was unable to tell that Committee how many such agreements had been made by NHS organisations under those arrangements, nor how much had been paid out, though figures obtained through requests to Trusts made under the Freedom of Information Act 2000 indicated that at least 50 such payments have been made by some 30 Trusts, to a total of approximately £2 million.

84. Treasury and Departmental approval is necessary for all payments made under compromise agreements to ensure that the agreements do not inhibit, or cover up, the disclosure of information in the public interest. However, as many as 50 compromise agreements between NHS bodies and former employees may have been reached through judicial mediation without any scrutiny by the Department of Health and the Treasury. Among these is the agreement signed by Gary Walker which the Committee has examined. **It is unacceptable that in several cases the payment of public money in settlement of claims against NHS bodies has not been subject to normal approval procedures by the Department of Health and the Treasury. The Committee welcomes the fact that Departmental and Treasury approval will be required before such payments are made in future.**

The case of Gary Walker

85. Shortly after the Committee took evidence from Robert Francis on his recommendations, it received evidence of a number of examples of people who had been asked to sign compromise agreements which they considered prevented them from raising issues of concern. The Committee considered the case of Gary Walker as an example of such agreements. Mr Walker, Chief Executive of United Lincolnshire Hospitals NHS Trust (ULHT) from October 2006 to February 2010, had been dismissed by the Trust in February 2010 on grounds of gross misconduct and lodged a claim for unfair dismissal with the employment tribunal.⁷⁶ The case was settled outside the tribunal in October 2011 when Mr Walker and the Trust entered into a compromise agreement to settle the claim. This agreement was facilitated through a process of judicial mediation.

86. The compromise agreement contained a provision that Mr Walker should not repeat the allegations contained in the witness statements served on the respondent (ULHT) during the employment tribunal proceedings, and that he would take “reasonable steps” by asking the other witnesses to abide by the same duty of confidentiality.⁷⁷ Mr Walker stated to the Committee that in entering into this compromise agreement he had been “gagged” by ULHT.⁷⁸ On 14 February 2013, an interview with Mr Walker was broadcast on the BBC Radio 4 *Today* programme, in the course of which Mr Walker alluded to certain concerns he had had over patient safety issues at ULHT. He declined to say more about his concerns, indicating that he had already received a letter from lawyers acting for ULHT, reminding him of the terms of his agreement and threatening action to recover the sums paid to him

75 Oral evidence taken before the Public Accounts Committee, 12 June 2013, *National Programme for IT*, HC (2013–14) 294-i

76 Between July 2009 and February 2010 Mr Walker was signed off from his duties on medical advice. His duties were undertaken by an acting chief executive.

77 Annex A to Mr Walker’s memorandum to the Committee, reported to the House on 19 March 2013 and published at <http://www.parliament.uk/documents/commons-committees/Health/FRA03GaryWalkerA-L.pdf>

78 *Ibid.*, para 109

under the agreement in the event that he proceeded with the broadcast. He also expressed a wish to have his case examined by this Committee.

87. Mr Walker, accompanied by Mr David Bowles, the former Chairman of ULHT, gave evidence to the Committee on 19 March 2013. Further details of the case and the Committee's observations following that session are set out in an annex to this report.

88. The Committee does not adjudicate on the substance of Mr Walker's allegation that in the spring and summer of 2009 he was placed under inappropriate pressure by the East Midlands Strategic Health Authority to take steps to meet access targets in ways which he considered would have compromised patient safety at ULHT: this allegation is vigorously contested. The Committee further notes that the Chairman of ULHT has since stated that it had no intention of proceeding against Mr Walker for discussing in public issues relating to patient safety at ULHT. Nevertheless, assuming that the outline of the issues to be raised with Mr Walker in the course of his interview with the *Today* programme which was provided to ULHT by the BBC fairly reflected the eventual content of that interview, the Committee can see no justification for the Trust and its legal representatives to have written to Gary Walker threatening action for breach of an agreement.

89. The Committee is concerned by the insensitivity and lack of discretion shown by United Lincolnshire Hospitals Trust and its legal representatives in seeking to restrain Gary Walker from discussing legitimate patient safety concerns. If this reaction is an indication of the prevailing culture in Trusts confronting those who seek genuinely to raise patient safety issues, then that culture must change.

Establishing a culture which is comfortable with challenge

90. As Robert Francis has indicated, a truly open professional and managerial culture which listens and responds appropriately to the concerns of staff and service users would render the role of the whistleblower redundant.

91. Prime responsibility for the propagation of an open and transparent culture in any provider rests with its Board. A Trust Board sets policies for the organisation, provides and sustains leadership, and through its actions indicates the behaviour which is and is not acceptable in the organisation.

92. As the Committee has already noted, it is also the responsibility of NHS commissioners to ensure that providers of NHS care operate an open and accountable professional culture because failure by care providers to meet this standard makes it impossible for commissioners to discharge their obligations to individual patients, local communities, NHS England, or the taxpayer.

The role of the CQC

93. The CQC, in its consultation on the post-Francis approach to provider inspection, proposes an approach which will, among other issues, examine whether a provider is well-led. The CQC says that "although leadership, governance and culture has not been a formal element of our existing approach, our experience has shown that these factors make the

difference between success and failure”.⁷⁹ The consultation proposes that an assessment of leadership in a provider be made against the following criteria:

By well-led, we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation, and an open, fair and transparent culture that listens and learns from people’s views and experiences to make improvements. The focus of this is on quality. For example, does a hospital board make decisions about quality care based on sound evidence and information about their services, and are concerns discussed in an open and frank way? Is there a good complaints procedure that drives improvement?

94. The Committee welcomes this approach to inspection, believing that it represents a crucial element in establishing an open and transparent culture in all care providers. The Committee notes that the CQC proposes initially to focus on provider governance arrangements. While a focus on Trust governance is welcome, the CQC should not prioritise this aspect to the detriment of its assessment of the openness of a Trust’s culture.

95. Changes in culture will not happen overnight. Developing cultures which allow concerns to be raised openly will require changes in attitude in many providers. In some cases it may well require changes in personnel. The best chance of securing genuine improvement in this area across the board will be for the CQC to work with commissioners to set challenging benchmarks for cultural norms within providers.

96. An important element of the development of an open culture will be the provision of support to staff who wish to raise concerns about care quality and patient safety. **The Committee recommends that the CQC should, in all its inspections of providers, satisfy itself that arrangements are in place to facilitate and protect the position of any member of staff who wishes to raise concerns about the quality of care provided to patients. As part of this process, the CQC should satisfy itself that proper safeguards are in place for whistleblowers who may provide an additional safeguard for patient interests.**

79 A new start: consultation on changes to the way CQC regulates, inspects and monitors care, June 2013

4 The NHS and its patients

Fundamental standards of healthcare

97. A significant number of Robert Francis' recommendations are devoted to the establishment of fundamental standards of healthcare across the NHS. The establishment of fundamental standards "for which there is zero tolerance of non-compliance, backed up by rigorous actions" was identified by Mr Francis as one of the overarching themes in his recommendations. He recommended that these fundamental standards should be accompanied by a governance system designed to ensure both compliance with them and the publication of accurate information about compliance.

98. In his report Mr Francis analysed the multiple sources of norms and standards which currently apply in the health sector. He identified Nolan principles, standards for GMC and NMC registrants, standards for other registrants with the Health and Care Professions Council, and standards for healthcare support workers, health service managers, Foundation Trust governors and board directors and NHS directors. Underpinning these standards are the "core values" of the NHS Constitution, a document which he believes has not yet had the impact it should in establishing those values.

99. Mr Francis recommended the establishment of an integrated hierarchy of standards, with clarity of status and purpose, coherence throughout the system and a clearly understood mechanism for setting and developing both the standards themselves and effective compliance arrangements.

[Healthcare] standards should be divided into:

- *Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance;*
- *Enhanced quality standards – such standards could set requirements higher than the fundamental standards but be discretionary matters for commissioning and subject to availability of resources;*

Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator.

All such standards would require regular review and modification.⁸⁰

100. In oral evidence Mr Francis explained that previous regulatory standards had been perceived, to a greater or lesser extent, as having been "handed down" to the health service by Government, meaning that there had not been a proper sense of ownership of standards

of care. He indicated what he meant by fundamental standards of minimum safety and quality:

What we need is a set of standards that are the result of a consensus between the public who are being served and the professionals who have to provide the service according to these standards, and then endorsed by Government. The sorts of things I have in mind [. . .] are that it should be regulated that it is unacceptable that a patient should be left in filth; it should be unacceptable that a patient is left without food and water; and it is unacceptable that a patient should not receive medication that has been prescribed. I am talking about extraordinarily basic things of that nature which we would all think would be provided day in day out in our hospitals but manifestly were not on some, at least, of the wards of Stafford.⁸¹

101. He clarified that he intended these standards to be ones which patients could recognise and establish whether they were being observed, rather than technical standards:

What I am talking about as a standard I call a “fundamental standard”, which is something that no sane person would ever accept not to be provided. If you have a minimum standard, a core standard, or whatever, I am afraid that evidence tends to suggest that that is what people work to and that is all they provide. I am talking about things that we used to assume were provided but we now know were not. They are things that a patient can recognise are not being provided, a member of staff there can recognise are not being provided, and, therefore, both can immediately take action to do something about it. My impression of the current standards regulated by the Care Quality Commission is that it may be that the Care Quality Commission understands, by going round, whether there is a breach of them or not, but you or I wandering around a ward would not know.⁸²

102. A failure to meet fundamental standards for a healthcare service would mean that the service in question was no longer being provided safely and should be closed:

In times of economic challenge, it must be even more important to protect patients and their safety by ensuring that there is openness and honesty in the system, and by that I mean that there is genuine honesty about what can and cannot be done. The reason I have concentrated on [. . .] the fundamental standard is that the very least we can expect of a national health service is that those who run it, at any level, tell us when something cannot be done safely and, therefore, we can no longer do it, and to re-order whatever the service is accordingly.⁸³

There is no point in us providing a service to patients that does them harm, which is a grim truth, and it is awful to have to say it. So we need to provide a service that does not do that, and, if we cannot do that, we need to think again.⁸⁴

81 Q14

82 Q17

83 Q35

84 *Ibid.*

Responses to the proposal

103. The Government has accepted the principle of defined fundamental standards, and has begun work with the CQC, Monitor, the Trust Development Agency, NHS England and NICE to develop “a small number of fundamental standards focusing on key areas of patient care”.⁸⁵ It has suggested that the scope of such standards should include :

- whether patients are getting the medicines they have been prescribed at the right time and the right dose, including appropriate pain relief;
- whether patients are getting food and water, and help to eat and drink if they need it;
- whether patients are being helped when they need it to go to the lavatory and not left in wet or soiled clothing or beds;
- whether patients are being asked to consent to treatment and all staff communicate with patients effectively about their care and treatment; and
- whether the environment is clean and hygienic.

104. The CQC has issued a consultation paper on its approach to setting and inspecting standards in healthcare providers. The consultation envisages three levels of standard against which providers will be assessed:

- **Fundamental standards**—a legal requirement for any provider to operate a service
- **Expected standards**—standards of care which users should expect as a matter of course
- **High-quality care**—standards set by bodies such as NICE with the purpose of driving and measure priority quality improvements in providers

105. The CQC proposes that there will be “immediate, serious consequences” for the healthcare services it inspects where care falls below the fundamental standards, including the possibility of prosecution. As Robert Francis recommended, the fundamental standards should be drafted so that anyone should be able to recognise a breach of them.

106. The CQC has proposed a debate on the formulation of fundamental standards of care, suggesting as examples the following:

- “I will be cared for in a clean environment.
- “I will be protected from abuse and discrimination.
- “I will be protected from harm during my care and treatment.
- “I will be given pain relief or other prescribed medication when I need it.
- “When I am discharged my ongoing care will have been organised properly first.

- “I will be helped to use the toilet and to wash when I need it.
- “I will be given enough food and drink and helped to eat and drink if I need it.
- “If I complain about my care, I will be listened to and not victimised as a result.
- “I will not be held against my will, coerced or denied care and treatment without my consent or the proper legal authority.”

107. The CQC proposes that the regulations establishing fundamental standards should allow the CQC to pursue breaches of fundamental standards without first having to serve a warning notice on the provider. It proposes that expected standards should be enforced through registration requirements and that the CQC should require providers who do not meet expected standards to implement improvements as a condition of continued registration.

108. The report of the Berwick Review recognises the importance of regulation based on fundamental standards, but suggested that quality improvement in health services would not be achieved solely through a reliance on regulation based on technical standards:

Regulation, especially using intelligent inspection by experts, does have an important role in setting out what is expected, monitoring the extent to which those expectations are met, and taking action when they are not met. Clear and prompt response to alarming signals [. . .] is crucial for quality control.

However, regulation alone cannot solve the problems highlighted by Mid Staffordshire. Neither quality assurance nor continual improvement can be achieved through regulation based purely on technically specific standards, particularly where a blunt assertion is made that any breach in them is unacceptable.

In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime.⁸⁶

The Committee's view

109. **The Committee agrees in principle with the proposal to establish a set of clear and unambiguous fundamental standards in such a way that patients, their relatives, clinical and auxiliary staff and NHS managers can immediately recognise unacceptable care and take appropriate action.**

110. The expectation in establishing such standards is of course that they will not be breached, and that consequences will follow if breaches occur. Providers will no doubt adopt systems which minimise the risk of such standards being breached and which alert staff to any risk that the standards might be breached. It is important in establishing a fundamental standards regime that providers and the CQC are alert to the risk that a rigid adherence to measures designed to avoid breaches of fundamental standards may lead to perverse consequences elsewhere.

111. Even on well-managed wards, health professionals are properly expected to prioritise their effort according to clinical need. It is inevitable that occasions will arise where a coincidence of higher clinical priorities which require urgent attention of staff will be a greater priority than the temporary discomfort caused to some patients when fundamental standards are unavoidably breached as a consequence. Above all, fundamental standards should not distort clinical priorities such that they put patients at risk.

112. The Committee believes that once it has been established that a breach of a fundamental standard has occurred, it is axiomatic that it is treated seriously, reported accordingly and investigated thoroughly. Regulatory consequences—including unannounced CQC inspections—may follow from breaches, but it is important that any regulatory action should be proportionate to the breach that has occurred, and that it concentrates on analysis and remedy of the circumstances which have led to the breach.

113. The Committee expects to examine the CQC’s progress in developing the full range of standards identified in paragraph 104 of this report in the course of its regular programme of accountability hearings.

Criminally negligent practice

114. The Government proposes that where the Chief Inspector of Hospitals, working within the CQC, identifies criminally negligent practice in hospitals, the CQC should refer the matter to the Health and Safety Executive to consider whether criminal prosecution of providers or individuals is necessary.⁸⁷ The Health and Safety Executive (HSE) will receive additional resources to enable it to take on the task of examining criminal breaches of fundamental standards in hospitals. The Committee notes that the HSE has recently commenced a criminal prosecution of the Mid Staffordshire NHS Foundation Trust under Section 3(1) of the Health and Safety at Work Act 1974 in relation to the death of a patient in April 2007, a case examined by Robert Francis.

115. The Berwick Review has recommended that in cases of demonstrably severe and wilful misconduct which result in “egregious acts or omissions that cause death or serious harm”, providers and individuals alike should be subject to criminal sanction. The proposed criminal offence of wilful or reckless neglect or mistreatment which Berwick recommends is modelled on a similar provision in the Mental Capacity Act 2005. While the Committee understands the relevance of this proposal and the issue it is intended to address, it is aware that there may already be provision in statute which enables such behaviour to be prosecuted as a criminal offence.

116. The Committee agrees that serious breaches of fundamental standards which risk harming patients, or which are directly responsible for the death or serious injury of patients, should be treated as criminal matters.

117. The Committee notes the recommendation of the Berwick Review that an offence of wilful or reckless neglect or mistreatment, applicable both to organisations and individuals, should be introduced. It considers that the proposal should be examined to

determine whether egregious acts or omissions on the part of individuals or providers that cause death or serious injury to patients can be prosecuted as offences under existing criminal statutes.

Standards on care at the end of life

118. Robert Francis did not, in the report of his latter inquiry, make specific recommendations on standards for care of the dying. Extracts from witness statements and independent case note reviews presented in the report of his first inquiry indicate that at Stafford General Hospital during the period under investigation there were several instances where patients who were dying received care which was below an acceptable standard.

119. The issue of care for the dying in NHS care has been analysed in greater detail by the team led by Baroness Neuberger established to review the use of the Liverpool Care Pathway. The report of the review⁸⁸ made a number of detailed recommendations on which the Committee has not taken evidence and which are still under consideration by the Department of Health, NHS England and the relevant regulators.

120. The Neuberger Review found that a number of the stories in the press and broadcast media about the use of the Liverpool Care Pathway (LCP) which had prompted the commissioning of the review appeared to have much in common not only with the complaints which had led to the establishment of the two inquiries into Mid Staffs, but also with several other media stories about the way elderly patients in acute hospitals had been treated. The review concluded that

Plenty of evidence received [. . .] shows that, when the LCP is used properly, patients die a peaceful and dignified death. But the Review Panel is also convinced, from what it has heard and read, that implementation of the LCP is not infrequently associated with poor care.⁸⁹

121. The Neuberger Review recognised the positive contribution which the Liverpool Care Pathway and similar approaches to end of life care have made to clinical decision-making.

The Review panel fully recognises the valuable contribution that approaches like the LCP have made in improving the timeliness and quality of clinical decisions in the care of dying patients. It is therefore vital that the comments which follow [. . .] do not result in clinicians defaulting back to treating dying patients as though they are always curable, for fear of censure.⁹⁰

122. The review has, however, raised wider issues about standards of care which are applied to dying patients. The review report observes that all doctors, nurses and healthcare staff should aim to provide care with compassion to all people at the end of their lives, and that “exceptional standards” of care are required in the care of people with co-morbidities,

88 Independent Review of the Liverpool Care pathway, *More care, less pathway: a review of the Liverpool Care Pathway*, July 2013

89 *Ibid.*, p 19

90 *Ibid.*, para 1.38

people in pain and people who are frightened, as well as in the care of distressed and anxious relatives: “yet exceptional standards are all too often noticeable by their absence”.⁹¹

123. The Neuberger Review has recommended the establishment of a “system-wide, strategic approach” to the improvement of care for the dying, to entail close cooperation between the GMC, the NMC, the medical Royal Colleges, the CQC, NHS England and the National Institute for Health and Care Excellence. This coalition of bodies should create and deliver a knowledge base, education, training, skills and commitment “to make high quality care for dying patients a reality”.⁹²

124. As part of this approach the Review recommends that the CQC should collaborate with patient groups to define standards for good-quality end of life care services, and then inspect against those standards. It is also recommended that:

- the CQC incorporate end of life care into the new inspection programme established by the Chief Inspector of Hospitals
- the CQC carry out a thematic review of the treatment of dying patients across all the healthcare settings it inspects
- NHS England and clinical commissioning groups work to drive up standards of care for the dying by improving their commissioning practices.

125. The evidence of poor care at end of life in the NHS which has emerged from the Mid Staffs inquiries, the review of the Liverpool Care Pathway and other press and broadcast media coverage is deeply disturbing. The Committee recommends that the National Institute for Health and Care Excellence should establish specific standards for end of life care designed to ensure that dying patients receive all the care they require to minimise their suffering.

The National Patient Safety Agency

126. The National Patient Safety Agency, established in 2001 as a Special Health Authority, had the core function “to improve the safety of NHS care by promoting a culture of reporting and learning from adverse events”, which it largely achieved through a Patient Safety Division, which operated the National Reporting and Learning Systems arrangements for recording and learning from patient safety incidents.

127. In April 2012 the National Patient Safety Agency was abolished as part of the Department of Health’s review of its arm’s-length bodies. Leadership on patient safety policy transferred to the NHS Commissioning Board Authority (now NHS England); the National Reporting and Learning System (NRLS) database of patient safety incidents transferred to Imperial College NHS Trust for a two year period from 1 April 2012 and was to be commissioned by NHS England; the National Clinical Assessment Service transferred to the National Institute of Health and Clinical Excellence (now the National Institute for Health and Care Excellence); the National Research Ethics Service was taken into the newly

91 *Ibid.*, p 38

92 *Ibid.*, recommendation 39, para 3.6

established Health Research Authority, and the commissioning of the three Clinical Outcome Review Programmes (formerly known as National Confidential Enquiries) transferred to the Healthcare Quality Improvement Partnership, a charitable body.

128. At the time, the Department explained that, as the NHS Commissioning Board was expected to provide national leadership on commissioning for quality improvement, the essential functions supporting this role undertaken by other agencies, including the NPSA, should be brought together within the mainstream work of the Board “to exploit the leverage that commissioning would provide in placing quality and safety at the heart of patient care.”⁹³ The NPSA’s functions, while still considered necessary within a system supporting wider quality and safety improvement, were not considered necessary to be delivered by an arm’s-length body and could be delivered elsewhere in the system.

129. The Secretary of State suggested that the Department’s commitment to patient safety remained, despite the decision to eliminate the agency which had as its principal focus the monitoring of patient safety in the NHS: he indicated that the change was intended to “mainstream” a commitment to quality through the NHS system.⁹⁴

130. The Committee is not convinced by this argument. While a commitment to patient safety needs to be promoted throughout the NHS, and is part of the role of the Commissioning Board, responsibility for operating the database of patient safety incidents has been in effect outsourced to an academic institution on a commissioning arrangement which will require renewal at regular intervals.

131. Robert Francis was himself critical of the present arrangements for the patient safety function:

Safety is such a crucial aspect of protecting patients, it is questionable whether it should be controlled by a body under pressure to ensure the delivery of economic and financial objectives as well as quality ones. Wherever the function resides, its resources need to be well-protected and defined.

Consideration should be given to the transfer of this valuable function to a semi-independent arm of the systems regulator.⁹⁵

132. The purpose of establishing the NPSA as a separate organisation was to create a single focus for concern about patient safety—as one key domain of clinical quality. It was an institutional reflection of the old principle of good medicine—“first do no harm”. Although the abolition of the NPSA reflects a welcome desire to reduce the number of regulatory and quasi-regulatory bodies in an over-crowded field, the effect of the present arrangements has been to give the appearance that the overall significance of patient safety in health policy has been downgraded and that the effectiveness of the patient safety function has been compromised. In particular the location of legacy responsibility with NHS England, as the main commissioner of care, rather than with the CQC as the principal regulator, appears surprising.

93 *Liberating the NHS: Report of the arm’s-length bodies review*, Department of Health, July 2010, para 3.57

94 Q474

95 *Francis Report*, paras 17.123 and 17.124

133. **The Committee has recommended before that prime responsibility for monitoring of patient safety practice and data should be a core responsibility of the CQC.⁹⁶ It repeats this recommendation in this report in order to re-establish the principle that this responsibility should be demonstrably at arm's length from both the Department and from NHS England. The Committee further notes that the definitions of patient safety incidents used by the National Reporting and Learning System focus only on incidents in taxpayer-funded healthcare. The definitions should be amended to cover patient safety incidents in private healthcare and taxpayer-funded social care services, both of which fall within the CQC's responsibility.**

Feedback and complaints

134. The Government has made few recommendations on reform to the NHS complaints system, pending the report of the review being undertaken by Rt Hon Ann Clwyd MP and Professor Tricia Hart. The Committee expects that the Government will, in its full response to Francis, consider the progress on relevant recommendations made in its 2011 report on *Complaints and Litigation*, as well as the recommendations relevant to the NHS which emerge from the present inquiry into complaint handling being undertaken by the Public Administration Select Committee.

135. Robert Francis was keen to stress the role which NHS commissioners should play in the complaints process, both as a matter of principle and as a means of checking that a proper service is being provided in return for the public money disbursed to providers. Information from individual complaints should therefore be available to commissioners as a matter of course: “if we have commissioners who are buying services, then they must have the means to check that those services have been delivered according to the specification that they have agreed with the relevant trust”.⁹⁷

136. Mr Francis considered the complaints system operated by the Mid Staffs Trust and concluded that it paid only lip service to good practice. Complaints were responded to, but often partially and inadequately. Where action plans were provided, there was little evidence that any action had followed from it: more often no action followed, “because we then see six months later the same thing happening in the same ward and the same sort of letter coming out with the same sort of action plan.”⁹⁸ Mr Francis concluded that greater transparency in the handling of complaints was the key to greater effectiveness in the system:

[. . . T]he substance of the complaints needs to be shared with the commissioners, the Care Quality Commission and—I see no reason why not in a suitably anonymised form—with the public. There would be visibility then as to what is happening about these things. If we are seeing a repeat of elderly patients breaking their legs because they have been falling over in a particular ward because no one was there to help them to the toilet, and that has happened two or three times, we will be

96 Health Committee, Seventh Report of Session 2012–13, *2012 accountability hearing with the Care Quality Commission*, HC 592, para 19

97 Q32

98 Q72

beginning to wonder whether this is a hospital capable of maintaining fundamental standards and, therefore, whether the service of this particular ward, or whatever the service was, should be allowed to continue. That is a commissioner's job, it seems to me, as well as the regulator's job. Between them, you have two organisations, at least, and in the background the public through patient involvement groups or whatever, being able to bring pressure to bear to make sure these things are done. I am not sure that changing the structure is necessarily the answer. There may be tweaks that could be made to it. It is about ensuring that the structure we have is acted on properly.

137. Mr Francis also recommended that Trusts make greater use of independent investigators to examine complaints, a practice which might help Trusts identify systemic issues which needed to be rectified: “if you do that, you get a report from an outsider who sets out things, one would hope, in a systematic way, and you have a report that may well identify systemic issues where they arise. That can be shared with the commissioner, the regulator and so on.”⁹⁹

138. The Committee agrees with Robert Francis that proper complaints handling is vital if organisations are to ensure that services are change for the better.

139. Robert Francis recognised that patients are often not willing to complain about poor care, for fear of adverse consequences, particularly if the complainant is bed-bound or in a similarly vulnerable position:

You have the nurses there, you have the patient there, and unless you change the culture and root out [intimidatory] behaviour—and that requires responsibility on the part of those running it—it is quite difficult to see the answer to that [issue]. The one answer I will give is that [a] PALS [Patient Advisory and Liaison Service] does not work in this context. It has its value, but its value is to do with facilitating communications, perhaps, and advice of that nature, rather than anything else. It is too intrinsic to the trust itself to be of help. You need more transparency. Part of what I have said is about being more welcoming to families and their involvement in what is going on, and the more people you have—the force of numbers—occasionally overcomes the vindictive nurse, one would hope. In so far as they exist—and we know they exist; they did at Stafford—it is, I am afraid, the duty of those around them to root that out. I cannot see any other answer to that.

140. Providers of NHS services should be alert to this issue. The Committee recommends that NHS providers should promote a culture of openness to complaints and receptiveness to feedback throughout their organisations, and they should also develop channels which allow patients and their families to make observations about poor standards of care in the confidence that there will be no detriment to the patient and will be taken seriously by the organisation. Any staff who deliberately treat patients poorly as a consequence of complaints being made should be held to be in breach of a fundamental standard of NHS care, and liable for the consequences.

5 Nursing and healthcare assistant staff in the NHS

Staffing ratios and patient care

141. Throughout Robert Francis' analysis of the warning signs ignored or not acted upon, the prioritisation of financial performance over considerations of adequate staffing appears to have been a significant factor in the poor care delivered at Stafford. One of his recommendations on fundamental standards of care specifically addresses this point:

The standard procedures and practice [for setting fundamental standards] should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff. These tools should be created after appropriate input from specialties, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff: patient ratios.¹⁰⁰

142. In oral evidence Mr Francis expanded on this recommendation:

To lay down in a regulation, “Thou shalt have N number of nurses per patient” is not the answer. The answer is, “How many patients do I need today in this ward to treat these patients?” You need to start, frankly, from the patient, as you do with everything. “How many nurses or what proportion of a nurse do I need to treat Mrs Smith in bay 3?”¹⁰¹

The obvious thing is that on a day-in-day-out basis, the ward sister, the director of nursing or whoever else it is in a hospital, needs to know, “I have enough nursing staff of the right calibre on this ward to deal with the patients I have there today.” The board needs to know that is happening on a day-to-day basis. In order to do that, having a standard in my regulations, as I will propose, that says, “Thou must have X number of nurses” will not, in my view, work—certainly not on what we know at the moment. What we need is evidence-based guidance, which, if followed, would mean that the hospital would say, “We have done our level best to produce that and actually we do have enough staff” We then need to look, if that is the position, at why the individual nurses are not providing the work.¹⁰²

143. While Mr Francis considered that one element of ensuring adequate staffing on the ward was the leadership provided by senior nurses in allocating staff properly and ensuring that they worked effectively, he recognised that leadership alone could not overcome the difficulties caused when wards were in fact fundamentally understaffed:

¹⁰⁰ *Francis Report*, recommendation 23, chapter 21

¹⁰¹ Q13

¹⁰² Q20

Leadership is about producing effective work from the work force that you have. But if you assume that your nurses are working effectively and you still do not have enough staff to go round, then that is where you have the problem. I am afraid all these things are difficult and I am not going to pretend they are not, but it is a combination of having enough staff and the right leadership. One without the other is not sufficient.¹⁰³

He was clear that Trust Boards needed to have enough information to determine whether they had enough staff on the ward to ensure that fundamental standards could be complied with:

What we need is to make sure, through the guidance, the research and the evidence base that every board has a means of knowing whether, on a day-to-day basis, a ward is [adequately] staffed. That is not quite the same as saying it is one of the fundamental standards. It is how you get to comply with the fundamental standards; it is how you deliver the fundamental standards.¹⁰⁴

Government response

144. The Government has recognised that high quality care on the ward requires “the right staff, with the right values, skills and training available in the right numbers”, and that the right staff mix “depends on the needs of patients on each ward at any time”.¹⁰⁵ The Government does not, however, favour the introduction of minimum staffing numbers or ratios, arguing that this would lead to a lack of flexibility in workforce planning as staffing decisions were made according to formulae rather than in response to the identified needs of particular groups of patients. The Government argues that skill mixes among the workforce are best determined by local providers rather than determined by Government, contending that local NHS organisations “must have the freedom to deploy staff in ways appropriate for local conditions.”¹⁰⁶

145. The Government’s response goes on to endorse Mr Francis’ recommendation that evidence-based guidance should be issued to inform local decisions on staffing levels, and proposes to work with NICE, the CQC and NHS England to develop such guidance. The new Chief Inspector of Hospitals in the CQC will have a remit to inspect staffing levels and to report if wards are inappropriately staffed, and the CQC is to require providers to use evidence-based tools to determine staffing numbers. *Compassion in Practice*, the Government’s nursing strategy, indicates that Trust Boards should receive, endorse and publish information on staff levels “at least twice a year”.¹⁰⁷

146. Questioned on how the Government proposed to implement the recommendation on evidence-based guidance on staffing levels, the Secretary of State indicated that it could be achieved through inspection of providers to ensure that they were complying with best

103 Q23

104 Q24

105 *Patients First and Foremost*, Cm 8576, para 5.2

106 *Ibid.*

107 *Ibid.*, para 5.6

practice on reporting staffing levels. He cited the example of Salford Royal Infirmary, which uses a management tool which adjusts recommended staffing levels to match the requirements of patients admitted to a ward, and suggested that providers who did not use similar tools would eventually be encouraged to adopt them to comply with the Chief Inspector's requirement for hospitals to demonstrate how they were meeting fundamental standards.¹⁰⁸

What that Robert Francis recommendation says is that every hospital should have a proper tool that is able to guide it accurately as to the number of staff needed. That is what we are talking to NICE about at the moment. Then we will be inspecting them against the use of that tool.¹⁰⁹

147. Salford Royal NHS Foundation Trust has provided a briefing note for the Committee on its staffing practices, together with the prototype design for a staffing board which it proposes to display on each ward to share information on the numbers of nursing staff on each ward with patients and relatives. These are reproduced at Appendix 2.

148. Una O'Brien CB, Permanent Secretary at the Department of Health, added that the development of data reporting would be essential to monitoring progress:

The essence of this is timely transparent data. We need to make sure that the tools are fit for purpose. There needs to be more work on the quality of evidence behind the tools. The second stage is to ensure that they are systematically adopted and, thirdly, that there is adjustment and management on a daily basis.¹¹⁰

The Committee's view

149. Good quality care in hospitals relies on the availability of sufficient numbers of clinically-qualified registered nurses supported by well-trained, properly-motivated and well-led healthcare assistant staff on wards who are dedicated to providing the best care possible for the patients entrusted to them. It is manifestly clear that this was far from the case on many of the wards at Stafford General Hospital. As a consequence, vulnerable patients suffered abuse and neglect which was in all cases disturbing and degrading, and in many cases is likely to have been dangerous.

150. Ensuring adequate levels of both clinically- and non-clinically-qualified staff in all circumstances is therefore a fundamental requirement of high quality care, whatever the financial circumstances. The Secretary of State has argued that this is not best achieved by attempting to set minimum staffing ratios for all circumstances, but by developing evidence-based guidance and expecting providers to respect the guidance.

151. The Committee believes that this approach will only win public confidence if it is supported by a clear commitment to open and public accountability for the staffing record of providers. While the Chief Inspector of Hospitals will have a role in inspecting staffing levels and ensuring that the tools used by hospitals deliver staffing levels which can meet

108 Q507

109 Q511

110 Q509

fundamental standards of care, the Committee does not think that periodic inspection of a provider's staffing practices is sufficient to achieve this on its own. Nor does it consider that twice-yearly reporting of staffing figures by Trust Boards is adequate to ensure proper staffing. Staff management practices in specialties where minimum staffing levels are mandated, such as paediatric care and intensive care, should be analysed for best practice recommendations.

152. The bodies which do have a continuing relationship with care providers, and an interest in ensuring the proper provision of services at local level, are commissioners of health and care services. As the tools for tracking and reporting on staffing levels are developed and refined, they will become more useful not only to Trust managers but also to commissioners and to the public. Tracking and reporting will also allow staffing levels to be compared against best practice benchmarks, especially for registered nurses. **The Committee recommends that commissioners should, via the NHS standard contract, require all care providers to collect information on the deployment of registered nurses and other healthcare staff at ward level on a daily basis, and make it available immediately to commissioners for publication in a standard format which will enable ready monitoring, analysis and comparison by all stakeholders. This should include making the information available in individual health and care settings.**

153. **The Committee has not undertaken an in-depth review of safe staffing issues, but has been impressed by the approach of Salford Royal NHS Foundation Trust to the development of a staffing management tool. This appears to the Committee to be good practice, and the Committee recommends the adoption of this or similar systems across the NHS.**

Training and status of nurses

154. The Government's initial response to the Francis report stated that every student seeking NHS funding to undertake a degree in nursing would be required to serve up to a year as a healthcare assistant as part of the nurse training programme. This would "promote frontline caring experience and values, as well as academic strength" and would provide helpful experience for students who would later be required to manage healthcare assistants after qualification. The Government has also suggested that the scheme might be extended to trainees in other (unspecified) fields of NHS activity. The proposal is in addition to a system of "values-based recruitment" to NHS careers which Health Education England proposes to introduce for all students entering clinical education programmes funded by the NHS.¹¹¹

155. Questioned about the merits of this proposal, the Secretary of State referred to evidence from Health Education England which indicated a high drop-out rate by those studying for nursing degrees following—and presumably as a result of—the practical experience element of the course. It was therefore desirable that those wanting to undertake nursing degrees paid for from public funds should be required to test their vocation for a period before taking up a place on a course.

111 *Patients First and Foremost*, Cm 8576, para 5.13

156. While the Secretary of State conceded that some nursing leaders had voiced opposition to the proposal, there was also “a great deal of support for it in parts of the nursing profession, particularly among some older nurses, who recognise this as being quite similar to how nurse training used to be.”¹¹²

157. Una O’Brien suggested that the measure was also intended to address an unwelcome separation between the role of the healthcare assistant and the registered nurse:

While it is true that we have to recruit for values across the piece for all professions, in the end it is the nurses who coach, train and line manage healthcare assistants on the ward. So they are in a unique relationship to that part of the work force. That provides a linkage between what the aspirant trainee nurse does and the actual outcome of how good they are in that supervisory role at the end of it. One of the lessons from the Francis report is the sense of a disconnect between the role of the healthcare assistant and the role of the qualified nurse; that was never intended by policy but it actually turned out to be the case in practice. What we want to see now is a much broader continuum drawn between those two very important professional roles.¹¹³

158. While a requirement to properly test a vocation before undergoing training for it at public expense is in principle worthwhile, the Committee questions whether the maximum twelve-month period proposed is necessary. The Committee is concerned that such a lengthy period of compulsory pre-training could itself deter potential recruits.

159. The Committee recommends that any proposal to require those seeking NHS funding for a nursing degree to first serve a period as a healthcare assistant should be fully piloted and carefully evaluated before full implementation in order to establish evidence about the value of the proposal and to determine the optimum length of time for such placements. The Committee also believes that it is important that such a system takes account of other lifetime experiences of potential trainees, including lived experience and voluntary work.

Nursing care for the elderly: the registered older person’s nurse

160. Robert Francis recommended the establishment of a new category of nurse, the registered older person’s nurse, in order to recognise the specific skills required from the nursing workforce to provide care for the elderly.

161. While the Government has recognised that caring for older people is “core to the job” of many nurses in hospitals and community care, and the proper care and support for the elderly requires removing barriers to service integration, it has decided not to proceed with the Francis recommendation, arguing that the elderly often require support from specialist teams with their own skills as well as from care workers in community and care home settings. Instead of establishing a separate role, the Government proposes to strengthen the overall focus of nursing and other healthcare training on the complex physical and emotional needs of older people. The Secretary of State explained to the Committee that

112 Q519

113 Q520

we just did not want people inside the nursing profession to think that older people's care was the job of specialist other people, when actually this is something that is central to everything that all nurses have to do in the modern NHS.¹¹⁴

Una O'Brien added that "there is a risk of putting older people's nursing into a silo, which is the opposite of what we want."¹¹⁵

162. The Committee agrees with the Government that training requirements for the healthcare workforce should properly recognise the complex needs of older people so that they can be addressed across the health and care system. While it is understandably undesirable to encourage the development of an older people's nursing silo, we agree with Mr Francis that it is also desirable to encourage the development of specialised skills and training in the care of the elderly. **The Committee sees no reason why registered nurses should not concurrently hold the status of registered older people's nurse, and we recommend that those nurses and care assistants who have successfully completed training in the skills required to care for older people should have those skills formally recognised and certified.**

Training and regulation of healthcare assistants

163. Robert Francis recommended the establishment of a registration and regulatory regime for healthcare support workers. Mr Francis makes this recommendation because he concludes that healthcare assistants are often mistaken by patients for the registered nursing staff responsible for delivering quality care:

A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship.)¹¹⁶

164. Mr Francis also recommended a code of conduct and national training standards to apply to such workers, all of which (registration, regulation, code of conduct and training) should be undertaken by the Nursing and Midwifery Council. The Department of Health should supervise these activities to protect patients from harm while the NMC prepared to adopt these responsibilities.¹¹⁷

165. The Committee has in the past supported the progressive development by the Nursing and Midwifery Council of a registration process for healthcare assistants: in its 2011 report on the NMC accountability hearing the Committee noted the lack of regulation for

114 Q570

115 Q571

116 *Francis Report*, recommendation 209, chapter 23

117 *Francis Report*, recommendations 212 and 213, chapter 23

healthcare assistants, and argued that the a statutory regulation scheme, operated by the NMC, should be introduced to cover healthcare assistants. The Committee also recognised that NMC performance of its current responsibilities has historically fallen well below acceptable levels and it did not favour extending the scope of regulation to cover healthcare assistants until NMC performance of its current core functions had demonstrably improved.¹¹⁸

166. The NMC subsequently confirmed that the Government had commissioned Skills for Health and Skills for Care to develop training standards and a code of conduct for healthcare support workers, which, alongside proposals for assured voluntary registration to be administered by the Council for Healthcare Regulatory Excellence (now the Professional Standards Agency for Health and Social Care) would provide “an effective framework for public protection.”¹¹⁹

167. The Government has resisted any form of regulation of healthcare assistants:

The idea of compulsory, statutory regulation can seem an attractive means of ensuring patient safety, yet Robert Francis’ report demonstrates that regulation does not prevent poor care. Regulation is no substitute for a culture of compassion, safe delegation and effective supervision. Putting people on a centrally held register does not guarantee public protection. Rather it is about employers, commissioners and providers ensuring they have the right processes in place to ensure they have the right staff with the right skills to deliver the right care in the right way to patients.¹²⁰

168. Instead, the Government plans to apply a version of the vetting and barring scheme operated by the Home Office to ensure that unsuitable healthcare assistants are not employed in care roles. The new Chief Inspector of Hospitals in the CQC is to provide assurance that hospitals are meeting their legal obligations to ensure that the barring regime is properly and consistently applied, and the new Chief Inspector of Social Care in that organisation is to ensure that unregulated care and support staff have the induction and training necessary to meet the registration requirements placed on their employers.¹²¹

169. The question of the induction, training and performance management of healthcare assistants is one of the issues addressed by Camilla Cavendish in the post-Francis review of training and support for healthcare assistants which she has undertaken for the Secretary of State. The Government undertook to review the subject again in the light of the report of Camilla Cavendish’s review.

170. The terms of reference of the Cavendish Review did not include mandatory registration for the healthcare assistant workforce, and this issue was not covered in the report of the Review.¹²² Cavendish did recommend that Health Education England should

118 Health Committee, Seventh Report of Session 2010–12, *Annual accountability hearing with the Nursing and Midwifery Council*, HC (2010–12) 1428, para 64

118 NMC response to the Seventh Report of the Health Committee, Session 2010–12, published as Appendix 2 to the Fifteenth Report of the Health Committee, Session 2010–12, *Annual accountability hearings: responses and further issues*, HC (2010–12) 1699

120 *Patients First and Foremost*, Cm 8576, para 5.22

121 *Ibid.*, para 5.23

122 *The Cavendish review: an independent review into healthcare assistants and support workers in the NHS and social care settings*, July 2013, para 2.1.3

develop certified qualifications for healthcare assistants, in the form of a Certificate and Higher Certificate of Fundamental Care. She further recommended that the CQC should require healthcare assistants in health settings, and support workers in social care settings, to have completed the Certificate of Fundamental Care before they can work unsupervised. She made further recommendations designed to establish caring as a career, and recommended that the Professional Standards Authority provide advice on how employers can more effectively manage the dismissal of unsatisfactory staff.

171. The Committee agrees that the issue of induction, training and performance management of healthcare assistants should be reviewed again in the light of the recommendations in of the Cavendish Review of training and support for healthcare assistants.

172. Healthcare assistants have an important and valued role, especially in caring for older people in their own homes and in formal care settings. The Committee believes that they should be encouraged and supported in undertaking continued professional development. The Committee does not believe the current unregulated status of healthcare assistants should endure, but it remains mindful of the need to ensure NMC performance improves before additional responsibilities are laid at its door.

6 The future of regulation

Regulating the system: the future of the CQC and Monitor

173. The Francis inquiry report revealed that the decision of Monitor to authorise Foundation Trust status for Mid Staffs in 2008 was made in ignorance of the serious concerns raised by the Healthcare Commission, the predecessor organisation of the CQC, about quality standards within the Trust.

174. The failure of Monitor and the Healthcare Commission to establish a proper basis of cooperation in the case of the Mid Staffordshire Trust led Robert Francis to propose that there should be greater institutional links between the two organisations. In particular he recommended that:

There should be a single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts.¹²³

He spelt out his recommendation in greater detail in his oral evidence:

My proposal is that one regulator, in assessing the safety of the hospital or the compliance with standards of the hospital, should be considering both what have up to now been called the quality outcomes but also the financial corporate governance that makes that compliance possible under one roof. That is not to say that the expertise that Monitor have in relation to looking at those matters is not absolutely valid—it is—but what we saw here was that dealing with them separately, under separate organisations, meant that one did not talk to the other. It might be said, “You can sort that out by getting one to talk to the other,” but I think you need the teams who do these things to be working together so that the perspective of each in the course of their investigations and so on feeds off each other so that we no longer have the issues of corporate governance being dealt with without people thinking to themselves, “How is this in itself impacting on patient safety?”

Therefore, I would envisage initially much the same people who do this in Monitor continuing to do it. It is simply that I believe they ought to have the same boss, if you like. I have not suggested one way or the other whether that means you get rid of Monitor or you amalgamate them, because there are other functions that Monitor perform. I see this as—and I said it should be—an evolutionary process because we have to keep such regulations as we have going while we do this. [. . .] [T]he important point is simply that this should be work that is done together for the benefit of patients rather than separating off the system bit from the outcome bit.¹²⁴

123 *Francis Report*, recommendation 19, chapter 10

124 Q47

The Government's response

175. The Government has indicated that it does not intend to accept this recommendation for a single regulator of provider quality and financial performance. Instead the Government proposes to establish a “single failure regime” which would treat failures in care quality as seriously as failures in financial performance. The Government's proposals were outlined in *Patients First and Foremost*:

In delivering this regime, the Care Quality Commission, Monitor and the NHS Trust Development Authority will work closely with each other and with commissioners, who will have a role in driving improvement and service change. We are mindful that this approach should not increase the overall level of regulatory burden, and in developing the regime we will consider the recommendations from the NHS Confederation's Review of Bureaucratic Burdens.¹²⁵

The single failure regime is to operate as follows:

The single failure regime will deliver a clear and co-coordinated regulatory approach to identifying and tackling failures of quality. There will be three elements to the proposed failure regime:

- *It is essential that there is a common understanding of provider performance amongst regulatory bodies and commissioners – a ‘single version of the truth’. There will be a single rating of providers led by the Chief Inspector of Hospitals at the Care Quality Commission which draws on information and assessments from Monitor and the NHS Trust Development Authority on finance. The Chief Inspector of Hospitals will champion excellent care. The regulatory bodies and the NHS Commissioning Board will agree a single national definition of quality, consistent with the Mandate and the NHS Outcomes Framework. This agreed quality framework will include consistent use of data to support assessment. The application of the national method will take account of the need to reflect, and not crowd out, local commissioner priorities. The Care Quality Commission will have an increasingly prominent role in Quality Surveillance Groups in assessing the quality of providers.*
- *Where quality is poor, the Chief Inspector will require the board of the provider with its commissioners to improve, within a fixed period. But the Care Quality Commission will not then be responsible for making it happen. The principle that responsibility for dealing with the problem lies with the provider, rather than external bodies, will not change. If the provider is unable to resolve the situation in partnership with commissioners, and problems persist, Monitor or the NHS Trust Development Authority would step in, potentially following a request from the Chief Inspector. Monitor and the NTDA retain their current ability to intervene at their discretion if urgent regulatory action is required. The same level of intervention will be possible in response to quality failings as for finance and governance failings.*

- *In some cases, however, it may become clear that more fundamental issues prevent an NHS foundation trust or NHS trust from making the necessary improvements in quality of care. For these rare cases of clinically unsustainable providers, we will ensure there is a suitable mechanism to ensure that the local population can access a comprehensive range of safe, sustainable health services.*¹²⁶

176. The proposed primary legislation to achieve the single failure regime and align the respective responsibilities of the CQC and Monitor has been included in Part 2 of the Care Bill [Lords]. The Bill was accompanied by a joint statement from the CQC, Monitor, NHS England and the NHS Trust Development Authority about how the newly aligned regime would operate.¹²⁷

177. The Secretary of State argued in evidence to the Committee that the effect of the proposed single failure regime would be that where a hospital breached fundamental standards the regime would make it “impossible for the system not to sort out the problem. There will be a time-limited period within which any of those breaches have to be sorted out, and if they are not, the hospital will go into administration.”¹²⁸

178. The Committee is sceptical that any failure regime can make it “impossible for the system not to sort out the problem”. The causes of failure within a major care provider are often numerous and complex; the Committee expects that the new model of inspection on which the CQC is presently consulting, and the operation of the single failure regime across all regulators, will require continual examination and tightening to ensure that both regulators are working effectively together.

179. The Committee does not support further major institutional change to the relationship between Monitor and the CQC. The Committee recommends that the two organisations continue to develop closer working arrangements to deal with cases of provider failure and shall seek evidence about the effectiveness of these arrangements from both organisations through its programme of annual accountability hearings with them.

180. Little of the detail of the regime set out in *Patients First and Foremost* and explained in greater detail in the quadripartite statement accompanying the Care Bill will be included in primary legislation, and although the policy approach has been set out, the detail of how it is to be achieved will be carried in secondary legislation. The changes to be made to the inspection functions of the CQC and its registration requirements are to be enacted through secondary legislation under the Health and Social Care Act 2008. While such legislation should pass through the affirmative procedure, enabling a form of debate before approval by each House, in practice secondary legislation laid before Parliament for enactment through this route is unamendable. There is substantial public interest in ensuring scrutiny of any draft before the Government’s proposed draft is formally laid for approval.

126 *Ibid.*, para 3.11

127 *The regulation and oversight of NHS trusts and NHS foundation trusts: joint policy statement to accompany Care Bill quality of services clauses*, may 2013, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200446/regulation-oversight-NHS-trusts.pdf

128 Q535

The Committee recommends that the Government publish for comment, prior to its formal introduction to Parliament, a draft of the legislation under which it is proposed to alter the inspection regime of the Care Quality Commission and the functioning of the single failure regime for Trusts and Foundation Trusts.

181. The Government has suggested that “outstanding” hospitals, as rated by the Chief Inspector, will be given “greater freedom from regulatory bureaucracy.” In the CQC’s consultation document on its proposed new inspection and ratings regime, it is proposed that the following criteria will have to be met for a hospital to achieve an “outstanding” rating:

- No breaches of fundamental standards
- No inadequate services, with most services rated as ‘Good’ or ‘Outstanding’
- Any breaches in expected standards are acted on quickly and effectively by the provider
- There is a range of evidence that the service is sustaining high-quality care (e.g. through consistently meeting NICE quality standards or achieving Royal College standards through clinical peer review) over time across most services in the organisation, with evidence of innovation
- No governance or finance issues from Monitor or the NHS Trust Development Authority.¹²⁹

182. The CQC proposes that inspection frequencies should be risk-adjusted: hospitals with an ‘outstanding’ rating should be inspected every three to five years, ‘good’ hospitals every two to three years, hospitals ‘requiring improvement’ at least once per year and ‘inadequate’ hospitals as and when needed.¹³⁰

183. The Committee welcomes the principle of ensuring that inspections are targeted and based on risk assessment, but believes that the CQC will need to continue to develop its thinking about the application of these principles based on evidence and experience. It has not been demonstrated to the Committee that proposals for the frequency of inspections have been based on such evidence. The Committee therefore recommends that these proposals should be supported by effective monitoring arrangements which will trigger an immediate inspection in cases where standards are alleged to be falling.

Inspecting the system: a Chief Inspector of Hospitals

184. In his response to the Francis Report, the Prime Minister indicated that he had asked the CQC to establish a Chief Inspector of Hospitals, to head a hospital inspectorate team within CQC. This was not one of the recommendations made by Robert Francis, though he indicated to the Committee on 12 February 2013 that he was not opposed to the idea.

¹²⁹ Care Quality Commission, *A new start: Consultation on changes to the way CQC regulates, inspects and monitors care*, July 2013, p. 30

¹³⁰ *Ibid.*, p. 31

185. The CQC has now recruited a Chief Inspector of Hospitals. Professor Sir Mike Richards is to begin the inspection of providers in the autumn of 2013. The CQC has also appointed Andrea Sutcliffe as Chief Inspector of Adult Social Care and Professor Steve Field as Chief Inspector of General Practice. Each inspector is to lead national teams of inspectors specialised in relevant aspects of care.

186. In respect of the Chief Inspector of Hospitals, the Government has indicated that the inspection team at the CQC will actively engage with other organisations “including Monitor, the NHS Trust Development Authority and the NHS Commissioning Board as a pivotal part of the single failure regime and the national ratings for hospitals.”¹³¹ The role of the Chief Inspector of Hospitals will be crucial in establishing the credibility of a hospital inspectorate within the CQC which commands public confidence. The inspectorate must be adequately resourced: while the Secretary of State indicated to the Committee that the inspectorate function would receive “as much money as they need in order to do this job properly”, he was unable to indicate the additional funding to be allocated to the CQC to support the inspectorate.

187. The Government indicated that the Chief Inspector of Hospitals would be “the nation’s whistleblower”, able to inspect hospitals without fear or favour and empowered to root out instances of poor care.¹³² As such, the Committee expects the Chief Inspector to play a significant role in driving openness and transparency across the NHS, not least by inspecting and reporting on the culture encountered in providers.

188. The Committee notes that the Chief Inspector of Hospitals is an official of the Care Quality Commission, leading the hospital inspection function of that organisation: although new methods of hospital inspection may be introduced, the CQC retains overall responsibility for hospital inspection. The Committee hopes that the substance of the role and the way it is exercised by its first incumbent justifies the rhetoric with which it has been introduced.

Regulating professionals

189. Robert Francis examined the role of professional regulators in his inquiry, both in terms of the regulatory oversight of professionals operating in the Mid Staffs Trust but also in terms of their general systems of professional oversight. He made this observation in oral evidence:

I have said they should be more responsive by way of not just sitting back waiting for a complaint to come in—and, of course, they must react to complaints—but, where they become aware, as they will do, of concerns about a system, they should be alert to considering proactively whether those deficiencies, which are being brought to light or of which they are made aware of, are due to a failing on the part of someone who is accountable to them and a breach of whatever their code of conduct is. That, I think, requires a different approach from the one that they have been undertaking to date. It requires in real life, I am sure, much closer co-operation with the systems

¹³¹ *Patients First and Foremost*, Cm 8576, para 2.9

¹³² *Ibid.*, para 12

regulator and possibly joining them in their investigations so that, if an investigation is taking place of a particular place, the professional regulators are involved in that.¹³³

190. The Committee proposes to examine the response of both the General Medical Council and the Nursing and Midwifery Council to the Francis recommendations in the course of its programme of annual accountability hearings, when it will consider the extent to which professional regulators ought to intervene when they have concerns about the operation of the regulatory system as opposed to concerns about the practice of their individual registrants.

Death certification reform

191. Reforms to the system of death certification, which were recommended by the report of the Smith Inquiry into the activities of Harold Shipman, were enacted in chapter 2 of the Coroners and Justice Act 2009 but have not yet been brought into force.

192. The reforms provide for an independent medical examiner to examine the cause of death of each individual and to enter the cause of death on the death certificate. Presently the examining doctor may enter the cause of death on the certificate, a procedure which has been shown to provide insufficient assurance that the cause of death has been effectively recorded.

193. Under the 2009 Act, primary care trusts were to be responsible for the establishment of independent medical examiners. As a consequence of the abolition of primary care trusts in the Health and Social Care Act 2012, responsibility for appointing medical examiners has been passed to local authorities, to be exercised once the provisions of the 2009 Act have been brought into force.

194. Recognising that the independent medical examiner system is not yet in effect, Robert Francis nevertheless made a number of recommendations on reform of the coronial and death certification system, particularly concerning the independence and resourcing of independent medical examiners and their approach to examining causes of death.

195. In addition Mr Francis recommended that healthcare providers should be under a duty to provide all relevant information to a coroner to enable him to perform his functions, unless there was a clear public interest justification for not doing so: this requirement, recommended as a condition of registration, should establish a duty of candour for a provider in respect of a coroner as well as in respect of a patient or relative.

196. Implementation of the medical examiner system following the transfer of responsibility to local authorities was to take place in April 2014. In itself this represents a delay of some five years since the enactment of the primary legislation, and comes over ten years since the report of a review of the system undertaken following the first report of the Shipman Inquiry.¹³⁴

133 Q58

134 *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003*, Cm 5831, June 2003

197. The Secretary of State conceded to the Committee that the timetable for implementation has now slipped, citing issues in relation to the charging regime and cooperation with local authorities: the Permanent Secretary indicated that there had been delays in drafting the relevant regulations as a precursor to consultation on them.¹³⁵ The Secretary of State later wrote to confirm agreement with the Local Government Association that the new system would be implemented in October 2014, following public consultation in the summer of 2013 and Parliamentary approval for the relevant secondary legislation early in 2014. He indicated that the Department proposed to include in its consultation measures to implement the further reforms proposed by Francis.¹³⁶

198. The Committee regrets the continued delay to implementation of the reform of death certification—a necessary reform to protect the public. The Committee notes the commitment of the Government to implementation of the new system in October 2014, and urges the Government to ensure that the timetable does not slip further.

199. Robert Francis has made some recommendations to the reform of death certification which do not depend on the implementation of the independent medical examiner regime, such as the duty of candour which providers should owe to coroners and the requirement that a consultant in charge of the treatment of a patient who dies in hospital should be personally responsible for certifying the cause of death. Implementation of these recommendations should not have to await the delayed date for introducing medical examiners.

200. The Committee recommends that the Government give early effect to the recommendations of Robert Francis in respect to coroners and death certification which do not depend on the introduction of the independent medical examiner system.

135 Q573

136 Ev 94

Annex: The case of Mr Gary Walker, former Chief Executive of the United Lincolnshire Hospitals NHS Trust

Shortly after the Committee took evidence from Robert Francis on the Mid Staffs inquiry recommendations, it considered the case of Gary Walker. Mr Walker, Chief Executive of United Lincolnshire Hospitals NHS Trust (ULHT) from October 2006 to February 2010, had been dismissed by the Trust in February 2010 on grounds of gross misconduct and lodged a claim for unfair dismissal with the employment tribunal.¹³⁷ The case was settled outside the tribunal in October 2011 when Mr Walker and the Trust entered into a compromise agreement to settle the claim. This agreement was facilitated through a process of judicial mediation.

The compromise agreement contained a provision that Mr Walker should not repeat the allegations contained in the witness statements served on the respondent (ULHT) during the employment tribunal proceedings, and that he would take “reasonable steps” by asking the other witnesses to abide by the same duty of confidentiality.¹³⁸ Mr Walker stated to the Committee that in entering into this compromise agreement he had been “gagged” by ULHT.¹³⁹ On 14 February 2013, an interview with Mr Walker was broadcast on the BBC Radio 4 *Today* programme, in the course of which Mr Walker alluded to certain concerns he had had over patient safety issues at ULHT. He declined to say more about his concerns, indicating that he had already received a letter from lawyers acting for ULHT, reminding him of the terms of his agreement and threatening action to recover the sums paid to him under the agreement in the event that he proceeded with the broadcast. He also expressed a wish to have his case examined by this Committee.

The Committee’s approach

The threat of action against Mr Walker by legal representatives of an NHS Trust appeared to the Committee to contradict the spirit of an assurance the Committee had received in oral evidence from Gavin Larner, Director of Professional Standards at the Department of Health, when he appeared before the Committee in December 2011 to address concerns that ‘gagging clauses’ were being used to inhibit regulated medical professionals from raising patient safety concerns. On that occasion Mr Larner said that

most of us absolutely agree that such clause are inconsistent with the Public Interest Disclosure Act [1998] and are not acceptable . . . There is a consensus here that we need to encourage people to speak out. With anything that hits against that, and in

137 Between July 2009 and February 2010 Mr Walker was signed off from his duties on medical advice. His duties were undertaken by an acting chief executive.

138 Annex A to Mr Walker’s memorandum to the Committee, reported to the House on 19 March 2013 and published at <http://www.parliament.uk/documents/commons-committees/Health/FRA03GaryWalkerA-L.pdf>

139 *Ibid.*, para 109

particular that crosses the [1998] Act, we need to make sure that the Service understands its responsibilities.¹⁴⁰

The Committee found the action by ULHT's lawyers surprising, coming as it did so soon after the publication of the Francis Report and the evidence given by Robert Francis in which he indicated explicitly that "what are commonly called "gagging clauses" should be banned, certainly in relation to patient safety".¹⁴¹ The Chair wrote to the Secretary of State to express concern and disappointment that, in the light of the Department's views and Robert Francis' recent recommendations, Mr Walker had received a letter which could be construed as reinforcing the 'gag' in his compromise agreement. The Committee invited both Mr Walker and the former Chairman of ULHT, Mr David Bowles, to give oral evidence on the concerns which lay behind the breakdown of Mr Walker's relationship with ULHT, and asked the Secretary of State to confirm that neither he nor any NHS body would seek to enforce any provision in the compromise agreement which would inhibit Mr Walker in responding to the Committee's request.

The Secretary of State wrote to the chairs and chief executives of all Trusts on 15 February to remind them of their obligations about public interest disclosures and to ensure that any confidentiality clauses in agreements with former employees embraced the spirit of Departmental guidance on public interest disclosures.¹⁴²

The Committee took oral evidence from Mr Walker and Mr Bowles on 19 March, and asked Mr Walker to submit the full text of his compromise agreement with ULHT, and a brief commentary setting out the actions of the Trust, the East Midlands Strategic Health Authority (SHA) and the Department of Health which in his view were designed to prevent him, or had the effect of preventing him, from raising issues of patient safety. Mr Walker and Mr Bowles both submitted written statements and supplementary material.¹⁴³ The Committee also received a submission on the matter and relevant material from the NHS Midlands and East SHA Cluster, representing the interests of the former East Midlands SHA.¹⁴⁴ Following the evidence session on 15 March the Committee received written statements from Sir John Brigstocke KBE, former non-executive Chairman and Dame Barbara Hakin, former Chief Executive of the East Midlands SHA.¹⁴⁵

The Committee Chair made it clear at the opening of the evidence session with Mr Walker and Mr Bowles on 19 March that the Committee had neither the power nor the means to make findings of fact in the matters of dispute between Mr Walker, the Trust and the

140 Oral evidence taken before the Health Committee on 7 December 2011, *Professional responsibility of healthcare practitioners*, HC 1699, Q83

141 Q34

142 The Secretary of State's correspondence with the Chief Executive of ULHT on the specific case is discussed below.

143 Reported to the House on 19 March 2013 and published at <http://www.parliament.uk/documents/commons-committees/Health/FRA03GaryWalkerA-L.pdf> and <http://www.parliament.uk/documents/commons-committees/Health/FRA03GaryWalkerM-Z.pdf> (Gary Walker) and <http://www.parliament.uk/documents/commons-committees/Health/FRA02-DavidBowles.pdf> (David Bowles).

144 Reported to the House on 19 March 2013 and published at <http://www.parliament.uk/documents/commons-committees/Health/FRA01-NHSMidlandsandEast.pdf>

145 Reported to the House on 16 April 2013 and published at <http://www.parliament.uk/documents/commons-committees/Health/FRA06-SirJohnBrigstocke.pdf> (Sir John Brigstocke) and <http://www.parliament.uk/documents/commons-committees/Health/FRA05-DameBarbaraHakin.pdf> (Dame Barbara Hakin).

former strategic health authority. The Committee's interest was in examining, as had Robert Francis, "the need for a culture change in the health service to make the service more open and to ensure that those with concerns about the safety and quality of care being delivered within the system feel able, empowered and encouraged to raise concerns where appropriate."¹⁴⁶

The Committee does not, therefore, propose to draw any conclusions on the dispute which arose between Mr Walker and Mr Bowles on the one hand and Dame Barbara Hakin and Sir John Brigstocke on the other. Messrs Walker and Bowles have set out their position in oral and written evidence and have provided additional papers, including papers which were subject to the confidentiality provisions of Mr Walker's compromise agreement. Dame Barbara Hakin and Sir John Brigstocke have both been afforded a right of reply to the evidence presented by Mr Walker and Mr Bowles, and their responses are now similarly in the public domain. The Midlands and East SHA Cluster has also made a submission in response to allegations made by Mr Walker in advance of the evidence session, and has provided its chronology of events.

Outline of the issues

In the course of the evidence session, Mr Walker and Mr Bowles made a number of statements about the pressures on ULHT hospitals, the relationship between the Trust and the commissioning authority (Lincolnshire PCT) and the relationship between the Trust and the strategic health authority (East Midlands SHA). Mr Walker made it clear to the Committee that he believed that the SHA had put inappropriate pressure on him to meet access targets, and that the measures he would have been required to take to meet such targets, given the Trust's existing capacity, would have threatened patient safety. He had therefore refused to take the measures required to meet access targets. In this he had had the support of the Trust Chair, Mr Bowles, and the Trust Board.

From April 2009 the dispute with the SHA over the actions which ULHT should take to meet targets apparently intensified, in a climate where concerns over patient safety had escalated following the publication in March 2009 of the Healthcare Commission report into Mid Staffordshire NHS Foundation Trust. In July 2009 both Mr Walker and Mr Bowles wrote to Sir David Nicholson, then Chief Executive of the NHS, to raise their concerns about the actions of the SHA in respect of ULHT and its management, indicating that in doing so they were making disclosures which they considered to be protected disclosures in the public interest. In the same month the SHA requested the Appointments Commission to suspend Mr Bowles as Trust Chair, a request to which the Commission assented. Shortly after the suspension took effect, Mr Bowles resigned. Mr Walker then took sick leave following a diagnosis of stress.

In August 2009, while still on sick leave, Mr Walker was notified by the new Chair of the ULHT Board that a disciplinary investigation had been opened against him following allegations both of bullying and harassment and of the use of inappropriate and offensive language as a matter of routine which had been made against him by another employee in an exit interview. While the allegation of bullying and harassment was not upheld, Mr

Walker was dismissed on the grounds of the use of inappropriate and offensive language in February 2010. Following an unsuccessful appeal against the dismissal, in April 2010 he lodged claims of unfair dismissal with the Employment Tribunal. In pursuit of his claim he presented evidence to the tribunal of 16 instances where he had made disclosures of information which it was claimed were protected disclosures within the meaning of the Employment Rights Act 1996 as amended by the Public Interest Disclosure Act 1998. It was submitted that he had suffered detriment as a result of having made these protected disclosures.

In April 2011, following an attended case management discussion between the parties, Employment Judge Britton made an order containing a number of judicial observations. Among these was an observation that two of the disclosures of information identified by Mr Walker as protected disclosures were *prima facie* protected disclosures under section 43G of the Employment Rights Act 1996, because they raised concerns about patient safety.

Britton EJ summarised the key issues of the case thus:

Is the Claimant [Mr Walker] correct in his contention that the disciplinary charges would never have been sustainable and certainly in terms of warranting a summary dismissal but for the preceding events: furthermore that a reason for the dismissal is the whistleblowing? And if so, what part of it? If there is no link between the whistleblowing and the dismissal, then it remains an ordinary unfair dismissal if that is what it was, and subject to the statutory cap. If a reason for the dismissal was the whistleblowing, then it becomes an automatically unfair dismissal and with no statutory cap on any award.

Finally, in the run up to the dismissal, was there in any event detrimental treatment of the Claimant? What would it be? Essentially it would have to be the bringing of, and the continuing with, the disciplinary charges. I say that because, as I understand it, the Claimant was never formally suspended in relation to the disciplinary matters as he was already off sick on health grounds.¹⁴⁷

Mr Walker contended that the judicial observation that there was *prima facie* evidence of a protected disclosure was a significant factor for ULHT to take into account in its negotiations. If the tribunal were to find that Mr Walker had been unfairly dismissed, and that the protected disclosure had been a factor in the unfair dismissal, then ULHT would have been liable to pay an uncapped sum in damages: otherwise the award would be have been capped according to the statutory formula in the Employment Rights Act 1996.¹⁴⁸

Mr Walker indicated to the Committee the difficulty of establishing that a disclosure of information was a protected disclosure in the public interest within the meaning of the Employment Rights Act 1996.¹⁴⁹ He contended that, even though the claim that he had made a protected disclosure which had been the primary cause of his dismissal had not been tested in the employment tribunal, the judicial observation that he had made a *prima*

147 Annex G to Mr Walker's memorandum to the Committee, reported to the House on 19 March 2013 and published at <http://www.parliament.uk/documents/commons-committees/Health/FRA03GaryWalkerA-L.pdf>

148 Section 119 of the 1996 Act.

149 Q429

facie protected disclosure had been sufficient to establish his *bona fides* as a whistleblower.¹⁵⁰

The compromise agreement, the “gagging clause” and the threat to Mr Walker

Mr Walker provided the Committee with a copy of the compromise agreement, and the Committee has ordered it to be published.¹⁵¹ It took effect on 24 October 2011, the date of signature. Mr Walker was required to take the advice of a qualified legal professional before signing the agreement, and submitted an affidavit to the tribunal confirming that he had done so.

As part of the compromise agreement with ULHT, Mr Walker received £325,000. Following deductions for legal fees of some £100,000, he said he had received a net sum of approximately £225,000.¹⁵²

The agreement contained the following clause, addressed to Mr Walker:

You agree that the dispute between you and the Respondent, the East Midlands SHA, the Department of Health and the Appointments Commission is hereby at an end and shall not repeat the allegations contained in your witness statement which were served on the Respondent during the proceedings. You agree to take reasonable steps by asking the other witnesses to abide by the same duties of confidentiality as are agreed by you under this Agreement.

Although section 43J of the Employment Rights Act 1996 provides that any confidentiality clause in an agreement or a contract of employment between a worker and an employer “is void insofar as it purports to preclude the worker from making a protected disclosure” within the meaning of the Act—including on issues relating to health and safety—Mr Walker, who had taken legal advice before signing the agreement, appears to have interpreted this clause as prohibiting him, and any other witnesses in his case, from making any private or public reference to matters contained in his witness statement or the documents he had presented to the tribunal, even though significant elements of his claim against ULHT rested on his contention that he had been unfairly dismissed in consequence of the concerns he had raised about patient safety at ULHT and his discussions with the SHA about such matters.

Mr Walker therefore appears to have construed the clause to mean that he had agreed not to speak openly about issues which he considered relevant to patient safety and which he had rehearsed in his witness statement. Any doubt that this was the case appeared to have been removed by the letter dated 12 February 2013 which he received from ULHT’s lawyers. In that letter the legal advisers to the Trust informed him that, “having seen an outline of the issues” which were to be discussed in the interview which Mr Walker planned to give to BBC Radio 4, the Trust had been advised that if Mr Walker had

150 Q436

151 Annex A to Mr Walker’s memorandum to the Committee, reported to the House on 19 March 2013 and published at <http://www.parliament.uk/documents/commons-committees/Health/FRA03GaryWalkerA-L.pdf>

152 Q421

provided an interview, or should the interview proceed, he would be “in clear breach” of the compromise agreement, with the consequence that the Trust would be entitled to recover from him “the payments made under the agreement and any costs including its legal costs”.¹⁵³ This statement was categorical and without qualification as to the content of the issues to be discussed.

The Committee asked Sir David Nicholson, NHS Chief Executive, how an NHS body had been in a position to issue, through its solicitors, a threat to an individual not to discuss certain issues in a planned radio interview. Sir David explained how he understood the situation had come about:

I absolutely and categorically deny that the Department warned off any individual from doing anything. What happened in those circumstances—and this is part of the public record and the *Today* programme would recognise it—is that the programme rang the hospital and asked them what they thought about that individual going on.¹⁵⁴

The Chairman of ULHT, Paul Richardson wrote to the Secretary of State on 15 February 2013 in response to a letter of the same date asking him to account for the Trust’s actions. In that letter he explained that the compromise agreement “contained standard confidentiality terms relating to the resolution of the employment tribunal dispute” and that “it was not intended to gag concerns regarding patient safety and complied with the relevant guidance and legislation at the time”; the letter from the Trust’s lawyers to Mr Walker was “a standard attempt by the Trust to remind him of his obligations under the agreement”. Had Mr Walker sought explicit permission from the Trust to discuss his concerns in a radio interview, the Trust would have made clear that he could publicly discuss them: the Trust’s position was that “this was always the intention and spirit of our compromise agreement with Mr Walker”, and that “at the point at which the agreement was reached it was fully compliant with [Department of Health] guidance.”

The Secretary of State has told the Committee that while the Trust’s position was that the relevant clauses of the compromise agreement were not intended to have a “gagging” effect, it was “unfortunate” that they had been perceived in this way.¹⁵⁵ Sir David Nicholson was more forthright:

The response of the hospital was wrong. They should not have got their lawyers to write to him to say that he should not talk about that compromise agreement. In the strict legal sense, he had signed a compromise agreement about the resources and what he was doing, but it was not covered. It was absolutely right, free and proper to speak out. If he feels he has something about patient safety to say, then he should be able to say it, and, if the hospital by accident—I do not know whatever arrangements happened at the hospital—put that letter out—they were wrong to do it. The spirit of it was wrong.¹⁵⁶

153 Paras 15 to 19 of Mr Walker’s memorandum to the Committee

154 Q224

155 Letter from the Secretary of State for health, Rt Hon Jeremy Hunt MP, to the Chair of the Health Committee, Rt Hon Stephen Dorrell MP, dated 25 February 2013

156 Q224

In his BBC interview broadcast on 14 February Mr Walker alleged, as he subsequently alleged to the Committee, that he was placed under inappropriate pressure by the East Midlands SHA to take steps to meet access targets, and that the measures which he would have had to take to meet such targets would have compromised patient safety.

The Committee does not adjudicate on the substance of this allegation, which is vigorously contested. The Committee further notes that the Trust states that it had no intention of proceeding against Mr Walker for discussing in public issues relating to patient safety at ULHT. Nevertheless, assuming that the outline of the issues to be raised with Mr Walker in the course of his interview with the *Today* programme which was provided to ULHT by the BBC fairly reflected the eventual content of that interview, the Committee can see no justification for the Trust and its legal representatives to have written to Gary Walker threatening action for breach of an agreement.

The Committee is concerned by the insensitivity and lack of discretion shown by United Lincolnshire Hospitals Trust and its legal representatives in seeking to restrain Gary Walker from discussing legitimate patient safety concerns. If this reaction is an indication of the prevailing culture in Trusts confronting those who seek genuinely to raise patient safety issues, then that culture must change.

Appendix 1: Correspondence between the Committee Chair and the incoming Chair of the Care Quality Commission

Letter from the Chair of the Committee, Rt Hon Stephen Dorrell MP, to the Chairman-designate of the Care Quality Commission, Mr David Prior

Use of confidentiality clauses in agreements between the CQC and its staff

I write in advance of you assuming your responsibilities at the Care Quality Commission on 28 January to raise a matter of concern to the Committee.

When we took evidence in December 2011 on the professional responsibility of healthcare practitioners we heard from the Deputy Chief Executive, Jill Finney, on the position of the CQC on the use of confidentiality clauses in compromise agreements between NHS staff and their former employers. This was followed up by a helpful supplementary memorandum which set out the CQC's position as it stood in more detail.

The use of confidentiality clauses in compromise agreements at the CQC itself was of course discussed in the Public Accounts Committee report of March 2012. That Committee reported that such clauses were tantamount to 'gagging clauses', and noted that Department of Health guidance to NHS organisations and Departmental public bodies makes clear that, while confidentiality provisions are not prohibited, clauses that seek to prevent the disclosure of information in the public interest should not be allowed.

Our view is that such clauses have no place in contracts or agreements between the CQC and its serving or former staff. While I acknowledge the argument that such clauses are relatively common in employment law, are agreed to by the counterparty only after legal advice has been sought, and do not prohibit disclosures made in the public interest, you will recognise that the use of such clauses naturally inhibits the disclosure of legitimate concerns about the functioning of an organisation, particularly where there is a risk of challenge to any public interest defence. As the CQC put it in its memorandum to us of December 2011, "A so-called 'gagging clause'... does not actually 'gag' a worker from making a protected disclosure, however we acknowledge the Committee's concerns that this is not widely accepted public knowledge."

As you will recall, while Committee members discussed whistleblowing issues with you in the course of your recent pre-appointment hearing, this specific point was not addressed. We would be grateful to have your views on the use of such clauses by the CQC at an early date following your arrival in post.

January 2013

Letter from the Chairman of the Care Quality Commission, Mr David Prior, to the Chair of the Committee, Rt Hon Stephen Dorrell MP

Thank you for your letter of 15 January 2013 about the use of confidentiality clauses in agreements between the Care Quality Commission (CQC) and its staff.

These confidentiality agreements, widely used in both the public and private sector, reflect the end line in the relationship between an employer and an employee. They are a statutory mechanism for settling employment related claims and disputes in the interest of both parties.

The *Public Interest Disclosure Act 1998* (PIDA) is clear that such agreements are void if they preclude a worker from making a protected disclosure. For such a compromise agreement to be valid the legislation also requires that confirmation is provided from the employee's legal or trade union representative and that they have advised on the content of the agreement.

CQC has revised the wording of its standard compromise agreements to include a statement making it clear to employees that such agreements do not prevent them from raising legitimate concerns through a protected disclosure.

CQC recognises and supports the need to encourage open cultures in NHS Trusts and other health and social care services. We are satisfied that the current protection provided under PIDA is sufficient to enable staff subject to such agreements to raise legitimate concerns that they believe to be in the public interest.

The Speak Up charter that was launched in October 2012 outlines the Commission's commitment to work with other regulators, professional bodies and trade associations to support people who raise concerns in the public interest. Under the charter CQC committed to:

- Work in partnership with other organisations to develop a positive culture by promoting openness, transparency, fairness, reporting and learning as an important and integral part of providing safer patient and public care.
- Adhere to the principles of this charter to foster a culture of openness which supports staff to raise concerns.
- Share expertise to create effective ways of breaking down barriers to reporting incidents and concerns early on.
- Exchange information, where it is appropriate and lawful to do so, in the interest of patient and public safety.
- Signpost individuals to support and guidance to ensure that they are fully aware of and understand their protected rights under the Public Interest Disclosure Act 1998.
- Seek to highlight issues where current law or regulations may restrict those who wish to raise a concern about a human error.

February 2013

Appendix 2: Implementing Safe Nurse Staffing in an NHS organisation: briefing note from the Salford Royal NHS Foundation Trust

Case Study Overview

The review of nursing establishments is complex and any method of determining staffing has limitations. There is no one solution to determining safe staffing and therefore triangulation of methods is essential. Using the combination of approach will provide greater confidence in the decisions taken. The setting of establishments should triangulate from three different sources:

- Workload measurement based information (acuity/dependency & activity) using a validated tool.
- Benchmarking with other organisations
- Professional consultation

We use a national model to determine our nursing establishments and assure ourselves that staffing numbers are adequate to deliver safe quality care. The model applied is the Association of United Kingdom University Hospitals (AUKUH). The AUKUH Acuity and Dependency Tool was developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool will also offer nurses a reliable method against which to deliver evidence-based workforce plans to support existing services or the development of new services.

The AUKUH Acuity/Dependency tool is based upon the classification of levels of care of critical care patients (Comprehensive Critical Care, DH 2000). These classifications have been adapted to support measurement across a range of wards/specialties.

We have until recently only completed part of the model where the identified number of beds for each ward, the WTE budgeted staffing numbers determine the nurse to bed ratio and this has been expected to be 1.1 or higher. This is based upon professional judgement and the numbers of qualified and unqualified nurses required to care for a designated number of beds. Currently all wards within SRFT go beyond 1:1 and meet this criteria in addition to the ratio of 1 registered nurse to 8 patients

Ratio of 1 RN to 8 patients

The Safe Staffing Alliance whose members are senior expert nurses issued an unprecedented warning in May 2013 that patient care is unsafe on wards where each nurse is looking after more than 8 patients. The 1:8 figure is based on evidence from Southampton University, Kings College London and National Nursing Research Unit. At SRFT we meet this figure as a minimum on all our wards during the day and in addition

there is a co-ordinator. All our sub speciality wards have a higher nurse to patient ratio than this, e.g. neuro.

We never have less than 2 registered nurses on a night shift and if such a rare occurrence should happen then the Executive on Call is notified. We are currently looking at a piece of work to consider 3 registered nurses on a night shift.

During June/July 2013 we conducted an acuity audit where each ward collected data based on the classification of levels of care at the same point each day for a period of 21 days in order to ensure a consistent approach. Some areas with high patient turnover collected data at three points during a twenty four hour period such as ICU, HCU, EAU etc. The collected data is then calculated using the model and it identifies the nursing numbers and skill mix required to provide care to this level of acuity/dependency of patient.

This audit will be conducted twice yearly (January and June) and it is anticipated that this acuity and dependency measurement will enable identification of trends across seasons and in response to changing demographics and healthcare needs. We envisage that this evidence base will support workforce plans for nursing and should accurately predict and enable resources to be identified to support nursing establishments.

12 Hour Shift Working

12 hour shift working has now been implemented in all areas of the hospital since July 2013. The liberated time from the implementation of this shift working is to ensure that all ward manager/matron are in a supervisory role to allow them to have overview of the ward and provide support to patients, families and staff. The supervisory ward manager role is encouraged on all wards, but when staffing numbers are reduced due to short term sickness or absence they are included in the establishment providing direct patient care.

These areas of work underpin our approach to ensure that establishments are set and that wards are staffed to provide safe care.

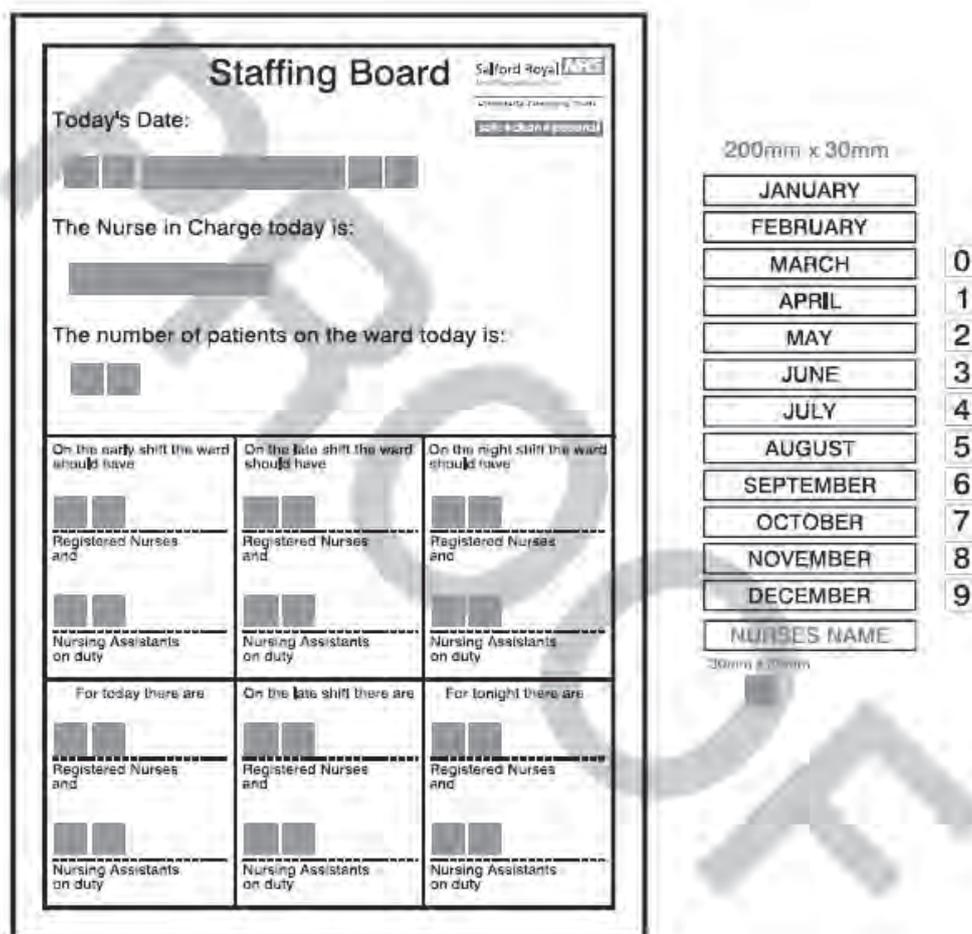
Safe Staffing Steering Group/Staffing Boards

To support this piece of work a Safe Staffing Steering Group is in place with membership consisting of senior nurses, quality improvement facilitator and workforce to address initially the use of the AUKUH staffing model. The group considers how we share with our patients and families in an open and transparent way the numbers of nursing staff on our wards at each shift by the introduction of staffing boards on every ward.

The board identifies the coordinator for the area and the numbers of registered and unregistered nurses that the ward should have and the numbers they actually have for the shift. Initially staff were concerned about the difficult questions that patients/families may ask if the number of staff actually on the shift was not the same as expected. This hasn't caused a problem. Early feedback from the use of the boards demonstrates they are extremely useful for patients and families and staff believe they are a good idea. A mock up board has been designed following early feedback and the design has been agreed and they are currently being produced. (Figure 1) The board will be displayed at the entrance to every ward and visible to all patients/family and carers.

We are working with our Quality Improvement Team to measure the reliability of the data so that we can determine how many days the actual staffing numbers present on the shift represented the planned numbers. We aim to demonstrate 95% reliability.

Figure 1: prototype of a proposed safe staffing board



Daily Safe Staffing Teleconference/Daily Rotas

Each morning at 8.30 am a teleconference is held with senior nurses across the clinical divisions, chaired by Deputy Director of Nursing to determine any nurse staffing concerns within their wards/departments. This looks at the morning, late and night shift and presents a true picture of what the nurse staffing actual is at that moment in time and therefore as up to date as possible. This allows a helicopter view and we can assess areas of concern and implement immediate actions to address the situation. The teleconference is an opportunity to assess areas of concern that may affect the clinical divisions.

To support this, a daily nursing rota is produced from all the clinical divisions. Nurse staffing is discussed at capacity meetings held four times daily. Senior nurse cover is provided 7 days a week and weekend rotas are discussed at the teleconference on Friday morning so a suitable plan can be put in place.

Learning

To implement safe nurse staffing requires commitment from all staff and not just senior nurse leaders. The Board need to be supportive and receive assurance of the staffing implications within the organisation. Involvement from the Finance Director is of real benefit to demonstrate corporate oversight of the advantages to efficiency and productivity as well as quality and safety.

We would recommend testing any change such as the staffing boards before a whole organisation spread so that amendments can be made.

We will expand the project to look at our staffing with community nursing teams, an area that hasn't produced much work nationally on minimum safe staffing.

To implement safe nurse staffing will be a continuous initiative that requires continual focus and leadership.

Conclusions and recommendations

The Francis Report and its significance

1. The importance of Robert Francis' report lies not only in its meticulous analysis of the system, identifying areas where misplaced assumptions, perverse incentives and the pursuit of natural human instincts inhibited the ability of the system to deliver high quality care, but also in its description of a culture where the most shocking and obvious deficiencies in care were apparently allowed to persist unchecked, with consequences for patients and relatives which were completely unacceptable. It is vital that the pervasiveness of this culture in many parts of the health and care system is recognised. (Paragraph 4)
2. Robert Francis has described a healthcare system established for the public benefit and funded from public funds which now risks an undermining of public confidence in its guarantees of safety and quality. (Paragraph 5)
3. The Committee is in no doubt as to the importance of the failures at Mid Staffs. It is vital to the interests of patients that the lessons from these failures are learned and acted upon, so that all patients can have confidence in the quality of care in the NHS. Without in any way detracting from the importance of this process, the Committee also believes that it is important to recognise that the experience of those patients at Mid Staffs who experienced poor care is not the day-to-day experience of millions of NHS patients treated each year by caring, experienced and committed staff. The purpose of highlighting the key lessons of the Francis Inquiry is not to undermine the NHS but to improve it. (Paragraph 6)

The Committee's inquiry

4. The Committee recommends that the Government should provide a response to the Committee's report in good time for it to be taken into account in the Second Reading debate in the Commons on the Care *Bill* [Lords]. (Paragraph 13)

Parliamentary oversight of professional regulation

5. The Committee agrees with Robert Francis' recommendation for its role in monitoring implementation of his recommendations. The Committee therefore proposes to enhance its scrutiny of regulation of healthcare professionals by taking public evidence each year from the Professional Standards Authority for Health and Social Care (the PSA, formerly the Council for Healthcare Regulatory Excellence) on the regulatory environment and the performance of each professional regulator, based on the PSA's own annual report. (Paragraph 14)
6. The Committee plans to draw on the views expressed by the PSA in its reports and in these sessions in preparing for its regular accountability hearings with the General Medical Council and the Nursing and Midwifery Council. It will also examine the case for inviting other professional regulators under the PSA's remit to appear before

it from time to time, in the light of the views expressed about their performance by the PSA. (Paragraph 15)

7. The Francis Report demonstrated that failure of professional responsibility was a key factor which contributed to failures of care at the Mid Staffordshire NHS Trust. The Committee has also consistently emphasised the importance of an open and accountable professional culture in its own reports during this Parliament. It welcomes Robert Francis' recommendation that there should be enhanced parliamentary oversight of the quality of professional regulation, and it intends to develop its relationship with the PSA to make this oversight as effective as possible. (Paragraph 16)

Open culture and professional responsibility

8. The Committee believes that Trusts and other care providers have a fundamental duty to establish an environment where concerns about patient safety and care quality raised by clinicians or managers are addressed openly and directly. (Paragraph 18)
9. The Committee agrees with Robert Francis that the key requirement is for a culture change within the NHS which values openness and transparency in all care delivery—not just when things go wrong. The duty of candour does not simply arise in cases of service failure; the requirement for an open culture which encourages challenge is fundamental to the delivery of high quality care. (Paragraph 21)

The existing duty and practice of candour in the NHS

10. The principles now set out in the NHS standard contract with regard to candour with patients are sound, but experience in Mid Staffs and elsewhere makes it clear that such principles have in the past been too often honoured in the breach rather than in the observance. Whatever additional safeguards may be introduced, the Committee regards the enforcement of these principles on all providers of NHS services as a fundamental part of the role of NHS commissioners. Failure to apply to these principles in practice should be seen as a failure of enforcement by commissioners as well as a failure of performance by service providers. (Paragraph 29)
11. Furthermore, the Committee believes that in the requirement for openness and transparency is too narrowly drawn in the NHS Standard Contract. The requirement for candour about mistakes should, in truth, be seen as part of a much wider commitment an open and accountable service. Challenge and debate about outcomes should occur at all levels of quality achievement and in all contexts of care, not just at the bottom. Indeed the Committee believes that if high quality service providers were to set the pace for openness and transparency by making properly anonymised information available on a dramatically improved basis, they would increase the pressure on less good providers to demonstrate that they were matching their standards to the best. Verbal commitments to high quality standards are virtually meaningless if no effective steps are taken to monitor performance. (Paragraph 30)

Accountability of commissioners

12. The Committee continues to believe that commissioners should be under an obligation to collect and publish full information about outcomes achieved for their communities, including a full account of failures to deliver acceptable standards of care. By failing to apply a duty of candour explicitly to commissioners, NHS England is losing an important opportunity to promote a more open and accountable culture throughout the NHS. (Paragraph 32)

The NHS Constitution

13. The Committee believes that the new formulation in the NHS Constitution explaining the duty of candour substantially understates the importance of a more open culture in the NHS. Commissioners and providers should be under a duty of openness about the full range of outcomes achieved, not just about examples of patient harm. More open accountability for outcomes achieved would be an important spur to improvements in the quality of care delivered across the full range of health and care facilities. It must be driven from NHS England, but it must permeate every aspect of care provision. It is the role of commissioners to ensure that the providers of NHS care provide timely, accurate and complete information to both individual patients and commissioners. (Paragraph 35)

The case for a statutory duty

14. The Committee believes that a defensive and sometimes over-legalistic culture which attaches a higher priority to avoiding liability than improving outcomes represents a pervasive phenomenon which is not confined to the healthcare system. While legal accountability is important, it is even more important that legal advice based on such defensive considerations is not allowed to impede the proper relationship between clinical professional and patient, based on sound principles of professional responsibility. (Paragraph 44)
15. Similarly, defensive and over-legalistic considerations of the best interests of Trusts should not be allowed to override the duty to be open and transparent with patients and relatives about adverse incidents, and to provide to them full explanations of the factors which led to such incidents. It is particularly important that NHS bodies provide full and candid explanations to relatives bereaved as a result of an adverse incident. (Paragraph 45)

The Committee's view on a statutory duty of candour

16. The Committee is mindful that NHS history is littered with examples of well-intentioned changes which have been superimposed on existing arrangements without sufficient attention being paid to the way in which it is proposed that the new arrangements will interact with existing processes. It is striking, for example, that the clauses in the Care Bill [Lords] which are intended to establish a criminal offence of providing false and misleading information—in effect criminalising a breach of the proposed statutory duty of candour—have specified neither the types

of provider, nor the types of information to which the offence will apply, leaving both to be specified later in regulations. (Paragraph 59)

17. The Committee remains to be persuaded of the case for the introduction of a statutory duty in addition to existing contractual duties and professional obligations. It is not clear that the proposed duty, the terms of which remain to be defined in secondary legislation, will constitute an effective means of achieving the fundamental culture change which is required within the NHS. (Paragraph 60)
18. The Committee continues to believe that it is mistake to think of the requirement for a more open culture specifically in the context of failures of care. The culture change which is required within the NHS requires greater openness across the full range of its activities—including examples of care that do not match current best practice, as well as overt failure. (Paragraph 61)
19. The Berwick Review recommends the commissioning of research into how best to support the proactive disclosure of serious incidents and the process of engaging with patients in relation to less serious incidents. While further research into these matters is necessary, and is likely in the medium term to make a positive contribution to candid dialogue between providers and patients, it should not delay the implementation of measures designed to entrench a culture of openness and candour across the full range of NHS activities. (Paragraph 62)

The Francis Report and whistleblowers

20. Robert Francis has recommended a change in the culture whereby it is easier, and more palatable, to raise a genuine concern than it is not to do so. The Committee agrees with this approach, although it recognises that there can be serious consequences for individuals who do raise their concerns. The management of each provider of NHS care has an unequivocal obligation to establish a culture in the organisation within which issues of genuine concern can be raised freely. Disciplinary procedures, professional standards hearings and employment tribunals are not appropriate forums for constructive airings of honestly-held concerns about patient safety and care quality. (Paragraph 69)
21. The Committee agrees with Robert Francis that providers of health and care, as well as their regulators, should be required to be open and transparent. Non-disparagement or ‘gagging’ clauses which inhibit free discussion of issues of care quality and patient safety are unlawful. No NHS body should be party to such an agreement or should seek to enforce an agreement in a way which inhibits free discussion of such issues. (Paragraph 76)

Compromise agreements at the Care Quality Commission

22. The Committee welcomes the assurance from the Chair of the Care Quality Commission that its standard compromise agreement now includes a clause making it clear to employees that such agreements do not prevent them from raising legitimate concerns through protected disclosures. The Committee recommends that the CQC should write to each employee or former employee with which it has an

existing compromise agreement to confirm that any non-disparagement terms of such agreements will not be enforced in cases where such persons wish to raise concerns which they believe to be in the public interest. (Paragraph 79)

Compromise agreements and severance payments

23. It is unacceptable that in several cases the payment of public money in settlement of claims against NHS bodies has not been subject to normal approval procedures by the Department of Health and the Treasury. The Committee welcomes the fact that Departmental and Treasury approval will be required before such payments are made in future. (Paragraph 84)

The case of Gary Walker

24. The Committee is concerned by the insensitivity and lack of discretion shown by United Lincolnshire Hospitals Trust and its legal representatives in seeking to restrain Gary Walker from discussing legitimate patient safety concerns. If this reaction is an indication of the prevailing culture in Trusts confronting those who seek genuinely to raise patient safety issues, then that culture must change. (Paragraph 89)

The role of the CQC in establishing a culture comfortable with challenge

25. The Committee recommends that the CQC should, in all its inspections of providers, satisfy itself that arrangements are in place to facilitate and protect the position of any member of staff who wishes to raise concerns about the quality of care provided to patients. As part of this process, the CQC should satisfy itself that proper safeguards are in place for whistleblowers who may provide an additional safeguard for patient interests. (Paragraph 96)

Fundamental standards of healthcare

26. The Committee agrees in principle with the proposal to establish a set of clear and unambiguous fundamental standards in such a way that patients, their relatives, clinical and auxiliary staff and NHS managers can immediately recognise unacceptable care and take appropriate action. (Paragraph 109)
27. The Committee believes that once it has been established that a breach of a fundamental standard has occurred, it is axiomatic that it is treated seriously, reported accordingly and investigated thoroughly. Regulatory consequences—including unannounced CQC inspections—may follow from breaches, but it is important that any regulatory action should be proportionate to the breach that has occurred, and that it concentrates on analysis and remedy of the circumstances which have led to the breach. (Paragraph 112)
28. The Committee expects to examine the CQC's progress in developing the full range of standards identified in paragraph 104 of this report in the course of its regular programme of accountability hearings. (Paragraph 113)

Criminally negligent practice

29. The Committee agrees that serious breaches of fundamental standards which risk harming patients, or which are directly responsible for the death or serious injury of patients, should be treated as criminal matters. (Paragraph 116)
30. The Committee notes the recommendation of the Berwick Review that an offence of wilful or reckless neglect or mistreatment, applicable both to organisations and individuals, should be introduced. It considers that the proposal should be examined to determine whether egregious acts or omissions on the part of individuals or providers that cause death or serious injury to patients can be prosecuted as offences under existing criminal statutes. (Paragraph 117)

Standards on care at the end of life

31. The evidence of poor care at end of life in the NHS which has emerged from the Mid Staffs inquiries, the review of the Liverpool Care Pathway and other press and broadcast media coverage is deeply disturbing. The Committee recommends that the National Institute for Health and Care Excellence should establish specific standards for end of life care designed to ensure that dying patients receive all the care they require to minimise their suffering. (Paragraph 125)

The National Patient Safety Agency

32. The Committee has recommended before that prime responsibility for monitoring of patient safety practice and data should be a core responsibility of the CQC. It repeats this recommendation in this report in order to re-establish the principle that this responsibility should be demonstrably at arm's length from both the Department and from NHS England. The Committee further notes that the definitions of patient safety incidents used by the National Reporting and Learning System focus only on incidents in taxpayer-funded healthcare. The definitions should be amended to cover patient safety incidents in private healthcare and taxpayer-funded social care services, both of which fall within the CQC's responsibility. (Paragraph 133)

Feedback and complaints

33. The Committee agrees with Robert Francis that proper complaints handling is vital if organisations are to ensure that services are change for the better. (Paragraph 138)
34. The Committee recommends that NHS providers should promote a culture of openness to complaints and receptiveness to feedback throughout their organisations, and they should also develop channels which allow patients and their families to make observations about poor standards of care in the confidence that there will be no detriment to the patient and will be taken seriously by the organisation. Any staff who deliberately treat patients poorly as a consequence of complaints being made should be held to be in breach of a fundamental standard of NHS care, and liable for the consequences. (Paragraph 140)

Staffing ratios and patient care

35. The Committee recommends that commissioners should, via the NHS standard contract, require all care providers to collect information on the deployment of registered nurses and other healthcare staff at ward level on a daily basis, and make it available immediately to commissioners for publication in a standard format which will enable ready monitoring, analysis and comparison by all stakeholders. This should include making the information available in individual health and care settings. (Paragraph 152)
36. The Committee has not undertaken an in-depth review of safe staffing issues, but has been impressed by the approach of Salford Royal NHS Foundation Trust to the development of a staffing management tool. This appears to the Committee to be good practice, and the Committee recommends the adoption of this or similar systems across the NHS. (Paragraph 153)

Training and status of nurses

37. The Committee recommends that any proposal to require those seeking NHS funding for a nursing degree to first serve a period as a healthcare assistant should be fully piloted and carefully evaluated before full implementation in order to establish evidence about the value of the proposal and to determine the optimum length of time for such placements. The Committee also believes that it is important that such a system takes account of other lifetime experiences of potential trainees, including lived experience and voluntary work. (Paragraph 159)

Nursing care for the elderly: the registered older person's nurse

38. The Committee sees no reason why registered nurses should not concurrently hold the status of registered older people's nurse, and we recommend that those nurses and care assistants who have successfully completed training in the skills required to care for older people should have those skills formally recognised and certified. (Paragraph 162)

Training and regulation of healthcare assistants

39. The Committee agrees that the issue of induction, training and performance management of healthcare assistants should be reviewed again in the light of the recommendations in of the Cavendish Review of training and support for healthcare assistants. (Paragraph 171)
40. Healthcare assistants have an important and valued role, especially in caring for older people in their own homes and in formal care settings. The Committee believes that they should be encouraged and supported in undertaking continued professional development. The Committee does not believe the current unregulated status of healthcare assistants should endure, but it remains mindful of the need to ensure NMC performance improves before additional responsibilities are laid at its door. (Paragraph 172)

Regulating the system: the future of the CQC and Monitor

41. The Committee does not support further major institutional change to the relationship between Monitor and the CQC. The Committee recommends that the two organisations continue to develop closer working arrangements to deal with cases of provider failure and shall seek evidence about the effectiveness of these arrangements from both organisations through its programme of annual accountability hearings with them. (Paragraph 179)
42. The Committee recommends that the Government publish for comment, prior to its formal introduction to Parliament, a draft of the legislation under which it is proposed to alter the inspection regime of the Care Quality Commission and the functioning of the single failure regime for Trusts and Foundation Trusts. (Paragraph 180)
43. The Committee welcomes the principle of ensuring that inspections are targeted and based on risk assessment, but believes that the CQC will need to continue to develop its thinking about the application of these principles based on evidence and experience. It has not been demonstrated to the Committee that proposals for the frequency of inspections have been based on such evidence. The Committee therefore recommends that these proposals should be supported by effective monitoring arrangements which will trigger an immediate inspection in cases where standards are alleged to be falling. (Paragraph 183)

Inspecting the system: a Chief Inspector of Hospitals

44. The Committee notes that the Chief Inspector of Hospitals is an official of the Care Quality Commission, leading the hospital inspection function of that organisation: although new methods of hospital inspection may be introduced, the CQC retains overall responsibility for hospital inspection. The Committee hopes that the substance of the role and the way it is exercised by its first incumbent justifies the rhetoric with which it has been introduced. (Paragraph 188)

Death certification reform

45. The Committee regrets the continued delay to implementation of the reform of death certification—a necessary reform to protect the public. The Committee notes the commitment of the Government to implementation of the new system in October 2014, and urges the Government to ensure that the timetable does not slip further. (Paragraph 198)
46. The Committee recommends that the Government give early effect to the recommendations of Robert Francis in respect to coroners and death certification which do not depend on the introduction of the independent medical examiner system. (Paragraph 200)

Formal Minutes

Tuesday 10 September 2013

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper
Andrew George
Barbara Keeley
Grahame M. Morris

David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Draft Report (*After Francis: making a difference*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 200 read and agreed to.

Annex agreed to.

Summary agreed to.

Papers were appended to the Report as Appendix 1 and Appendix 2.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Tuesday 8 October at 4.00 pm]

Witnesses

Tuesday 12 February 2013

Page

Robert Francis QC, Chairman, The Mid Staffordshire NHS Foundation Trust Public Inquiry

Ev 1

Tuesday 5 March 2013

Sir David Nicholson KCB CBE, Chief Executive, and **Professor Sir Bruce Keogh KBE**, Medical Director, National Health Service (England), and **Liz Redfern CBE**, Director of Nursing, NHS South of England.

Ev 23

Tuesday 19 March 2013

Gary Walker, former Chief Executive of the United Lincolnshire Hospitals NHS Trust, and **David Bowles**, former Chair of the United Lincolnshire Hospitals NHS Trust.

Ev 51

Tuesday 23 April 2013

Rt Hon Jeremy Hunt MP, Secretary of State for Health, and **Una O'Brien CB**, Permanent Secretary, Department of Health.

Ev 71

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List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2013–14

First Special Report	2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13	HC 154
Second Special Report	2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee's Tenth Report of Session 2012–13	HC 172
Third Special Report	2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee's Ninth Report of Session 2012–13	HC 581
First Report	Post-legislative scrutiny of the Mental Health Act 2007	HC 584
Second Report	Urgent and emergency services	HC 171
Third Report	After Francis: making a difference	HC 657

Session 2012–13

First Report	Education, training and workforce planning	HC 6-I (Cm 8435)
Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132 (Cm 8439)
Fourth Report	2012 accountability hearing with the General Medical Council	HC 566 (Cm 8520)
Fifth Report	Appointment of the Chair of the Care Quality Commission	HC 807
Sixth Report	Appointment of the Chair of the National Institute for Health and Care Excellence	HC 831
Seventh Report	2012 accountability hearing with the Care Quality Commission	HC 592
Eighth Report	National Institute for Health and Clinical Excellence	HC 782
Ninth Report	2012 accountability hearing with the Nursing and Midwifery Council	HC 639
Tenth Report	2012 accountability hearing with Monitor	HC 652
Eleventh Report	Public expenditure on health and care services	HC 651 (Cm 8624)

Session 2010–12

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)

Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)
Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and further issues	HC 1699
Sixteenth Report	PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)

Oral evidence

Taken before the Health Committee

on Tuesday 12 February 2013

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper
Andrew George
Barbara Keeley
Grahame M. Morris
Mr Virendra Sharma

Chris Skidmore
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witness

Witness: **Robert Francis QC**, Inquiry Chairman, gave evidence.

Q1 Chair: Mr Francis, you are very welcome to the Committee. You have devoted what must seem a very long period of your life to examination of a tragedy in Mid Staffordshire. We look forward to discussing your extensive report with you.

I would like, if I may, to open the questioning by referring to what is, I think, the core theme that comes out of your report, and that is the importance of achieving a change of culture, building on the lessons of what went desperately wrong at Mid Staffordshire. I want to link the concept of culture with the concept of accountability. I do not pretend to have read every word of every volume, but I have read the summary of your report and I was struck by page 37, paragraph 112, where you say: “Individuals and indeed organisations acting in accordance with a culture ... cannot always be held personally responsible for doing so.”

That seems to me to encapsulate one of the central dilemmas here, which is whether individuals who fail in their professional duty can attribute that failure to a failure of culture or whether they should be held personally accountable for what they did on the day. I would like to open the session by exploring how you feel we should exonerate individuals for personal failings simply on grounds of culture.

Robert Francis: Chairman, thank you. Can I start by putting this in the context of my terms of reference, which were very much to examine the actions or inactions of organisations? I was specifically steered by the terms of reference to examine the culture of those organisations against a background of the most appalling care that has been given to large numbers of patients in circumstances where people were saying, “We didn’t know about it”, but, on examination, it appeared there were any number of warning signs that, if looked at from a patient’s point of view, might have led to a different result.

There would have been two ways of running an inquiry of this nature, it seems to me, and that would have involved possibly different terms of reference from the ones we had. The way I approached it, given my terms of reference, was to seek to find out from as many people as possible involved in what actually happened in and around Mid Staffordshire what they did and did not do, and what their explanation was for

that; through that, to build up a picture of people’s thinking; and, at the end of the day put that in a report and, to that extent, hold up a mirror not only to the organisations but also to those individuals to show them and the public in general what had happened and perhaps why it had happened.

I then went on to make recommendations, to draw the lessons for the future. Clearly, one of those lessons is that there is insufficient accountability in this system. It is for that reason that I make a number of recommendations in that regard. I have said in the seminars that I ran—so it is not something that was new to the report—that it was quite clear to me that there was what I described at those seminars as a tsunami of anger heading towards the NHS. The reason was that there was this complete—not “complete”; that would be unfair; there was an absence of thinking on a daily basis about the impact of actions on patients. But there is a lack of accountability for the leaders of the service. I use the word “leaders” as meaning anyone, from a sister running a ward to the head of the NHS or the Secretary of State. They are all leaders and they all have different responsibilities.

The alternative way of running this inquiry would have been to have as one of its terms to identify the individuals responsible for this disaster. That inquiry would have had to have been a fair process. You cannot try people without it being fair. I personally think that would have had a number of unfortunate results. The first, which is important, would have been the duration and expense of the inquiry. Every single person involved would have instructed lawyers and every single person would have had to have been a core participant. I know some have criticised the length of my inquiry as it was, but I think we would have been running this inquiry for years and the lessons would not have been learned.

But perhaps the most important point would be that I do not think we would have found out as much as we did. It is obviously a matter of opinion, but I took the view that I was given as full disclosure by individuals as I could reasonably expect in a complicated matter. I have not accepted absolutely all the evidence I have heard, and you will see where I have and where I have not. But, on the whole, I believe that this inquiry

produced a picture—a very unhappy picture—of the system, which would not have been produced, and certainly not produced in the time that it was, if I had taken the course of looking at it through the individual perspective as opposed to the organisational perspective. That is the first point.

If I am going on too long, please tell me, but a more direct answer to your question is this. Of course, in one sense everybody who works in a service is personally responsible for their actions and has to reflect on that. But if you identify, as I have identified, an ingrained culture of “doing the system’s business”, which is the way I have described it, rather than focusing on the patients, culture can get to the point where it is a habit and, at the end of the day, it is a habit everyone in the system has. A culture is sometimes defined as “the way we do things around here”. It may need a cathartic moment in which everyone becomes aware that that is how the system is running and that it clearly needs to change.

That is really what I meant—and I have now given far too long an answer—by the rather short sentences in the report on responsibility and accountability.

I really do not believe that this report exonerates people at all. I can say that. I do urge those who have not done so to read the accounts given of the history in the various chapters about the organisations where I set out in detail what individuals have done and have not done, what letters they got and what their reaction was to those letters. Others may disagree, but I personally believe that that is the useful contribution a public inquiry can make to this situation.

Q2 Chair: Accepting that your inquiry was not a trial—that is the first part of the answer you have given, which explains the difference between the two, and I do not want to go into that—what I do want to go into is what the nature of the culture change is that you are looking for. Surely, absolutely at the heart of that culture change needs to be a greater individual acceptance of responsibility, including the responsibility for people to be difficult with their professional or managerial colleagues when they see something going on that should not be going on. Isn’t that absolutely what the culture change is all about?

Robert Francis: I could not agree more, Sir. It is absolutely important that everybody in the health service, from top to bottom or bottom to top, whichever way round you wish to put it, understands their own personal responsibility for changing this culture. There are any number of different ways in which that can be done, but in one sense it does not require any of my recommendations for people to do it. My recommendations are intended to encourage them—in some cases forcibly encourage them—to change. But I do think, whatever the field of activity it is, that people will have a responsibility for demonstrating their commitment to the re-orientated culture and that there are different ways in which individuals will be able to do that. A nurse can do it by showing care and compassion to patients. The leader of a trust can show it by promoting openness and transparency. People further up the chain can show it by honesty in relation to whether a service

can be provided or not or the provision of balanced information, by way of examples.

Q3 Chair: All of those things are important. I will have one more go and then I will allow my colleagues in. That is expressing it positively, and, of course, we all prefer the positive, but occasionally, as human beings, we see something go on that should not be going on. If the culture change is to happen, then we have to have a position where individuals accept their responsibility, as I have said, to be difficult about the people working round them and say, “That should not have happened and, if they don’t report it, I am going to.”

Robert Francis: Yes. I make a number of recommendations designed to reinforce that very important need. I recommend that not only should there be a duty, for instance, on individuals to refer things to their managers but there should be a criminal offence for obstructing that duty. I recommend that there should be accountability by way of allowing leaders of organisations to be disqualified from eligibility should they breach the rules in a very serious way. I am very much in favour of personal accountability, but in order to impose that you need to have the structure to do it, and, unfortunately, we have now discovered that has not been there at least for a significant swathe of the service.

Q4 Valerie Vaz: Can I start by saying that we are all very grateful for your report and the time that you have spent doing it? It must have been quite difficult and in some cases quite harrowing. Forgive me that I did not read all three volumes of the report, but I did read all the recommendations and it feels like it is a doughnut in that, whether or not it is a ring or a jam doughnut—and that is a wrong kind of analogy to use on a Select Committee—in the middle, the jam or the hole is missing, and there does not seem to be a reference to money. How are any of those recommendations—we hope all of them—going to fit in with the current culture of the efficiency savings in the NHS?

Robert Francis: I agree that my inquiry did not look at the finance, partly, I suspect, because, in one sense, I was not asked to. The essential issues that I was looking at were about the absence of what I have called fundamental standards from the service. What I have sought to try and do is suggest a way in which there can be recognition and enforcement of fundamental standards, by which I mean the sort of things that were going on which no one would ever agree should be tolerated. If I can put it bluntly, that is not an area in which cost should be relevant. If you cannot afford to provide a service in which people are cleaned and fed properly and get their medication when it is prescribed and so on, then it should not be a service at all. Therefore, one starts from that position. Obviously, the recommendations that I make need to be looked at in the context of money, but can I say this? It was specifically part of my role in the terms of reference to take account of the system as it now is. As you might imagine, over the last two years that has been, for me, a moving target and I make no criticism of that, but it was a challenge. One of the

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reasons I had not recommended the creation of new organisations and so on is partly because we do not want reorganisation. Also, I have done my very best to make as little change to the system as possible but by inserting into the system ingredients that put the patient first rather than the system's business. I hope that can be done within existing budgets, but we will have to work that out.

Q5 Valerie Vaz: I have one quick follow-up. There are some amazing recommendations—all 290 of them—and I wondered if the Secretaries of State, old or new, mentioned to you about coming back and revisiting whether any of those recommendations were going to be put through. Do you have a brief to report back to the Secretary of State after the institutions have had a chance to look at the recommendations and implement them? Are you revisiting them?

Robert Francis: No. My brief, as you put it, ends with the end of this inquiry, as it stands. I was clearly anxious, as I say, that this report should not suffer the fate of some in the past. I believe there is in fact a consensus that it should not do so, but I was anxious that a way should be found to ensure that there was a continual review of that. You will see that the way I proposed is to involve yourselves, should you see fit to do that.

Chair: Thank you for that.

Robert Francis: Can I just say this? First, it has been clear to me—and I have quoted your reports in my own—that this Committee takes its job very seriously. Secondly, it does seem to me important that there is a democratic continued accountability, if you like—a review of progress in such an important area. That is not something I could ever provide even if I was asked to do it. Clearly, having spent three years of my life listening in horror to the stories I have heard, I cannot just walk away and forget I have ever done it and put it in the bag like another barrister's case. It is just not like that. But, no, I have not been given a brief to continue to look at it, but will I continue to take an interest? Of course I will.

Chair: Thank you. Several colleagues want to come in, but I know Virendra needs to go so I will bring him in first.

Q6 Mr Sharma: You talked about changing the culture and that culture had been going on for many years. Individuals are part of that culture and you have not made any recommendations in regard to individuals. When you want to change that culture, the attitude of staffing and the board members at that time, would you expect system or professional regulators to take action against individuals as a consequence of the findings of your report?

Robert Francis: That is a matter for them. I have made observations in the report about the conduct of the regulators in the past when they have not, in my view, been sufficiently proactive in going and looking for individuals who are accountable under their codes of conduct for the things that are found wrong in a system. I believe they need to change in that regard. I have not said that individuals should not be held to account; clearly they should be where it is possible to

do so. So I would endorse that. If you take the report of my two inquiries together, I believe you would find areas that are worthy of investigation and, as far as I know—you will have to ask them—they have been doing so.

Q7 Chris Skidmore: The Health Secretary spoke about the possibility of a police investigation into individuals involved in this scandal. Would you endorse that?

Robert Francis: If there is going to be a police investigation, then possibly I should not comment on it. I can tell you, because it is in the report, that certain of these cases have already been investigated by the police—at least one of them springs to mind—and the Crown Prosecution Service decided there was no evidence to prosecute. It is not that there has been an entire absence of police investigation. I do not think I could comment in advance of a police investigation whether it was worthwhile or not. If there are crimes committed, then, of course, that is so, but one of the recommendations I make, I am afraid, is to produce a wider range of criminal offences that could be looked into than currently exist. At the moment, you have the opportunity of an individual manslaughter charge and there may be possibilities of offences in relation to wilful neglect of vulnerable people, but—and it is not for me as I am not a criminal lawyer—there did not seem to me to be a range of criminal sanctions available to reflect the sorts of terrible things that I found but which do not necessarily fit easily into a criminal category. More than that I think it would be unfair for me to say.

Q8 Barbara Keeley: On the same theme you recommend the introduction of a fit-and-proper-person test for all directors of bodies registered by the CQC and all the foundation trusts registered by Monitor, including a requirement to abide by a prescribed code of conduct. From the evidence you have seen, what risk is there that some present directors of NHS bodies might not pass that test, and should in fact the test be applied retrospectively? As part of what we have just been discussing, should those things you have recommended now be retrospectively applied?

Robert Francis: I have not recommended retroactivity and I think that would be difficult to do, except in this way. If you impose a fit-and-proper-person test, as I have suggested, then the issue is, “Is the person a fit and proper person today?”, and one of the things, no doubt, one could look at is history. Before one gets there, one not only needs a fit-and-proper-person test, but there has to be some means of due process to allow a judgment on that to be formed. In general, it is unfair—and probably, in certain circumstances, unconstitutional—to make things like this retrospective. But just as if you are employing someone to do a job, where you can look at what they have done in the past, no doubt the same, to some extent, if defined, could apply in a fit-and-proper-person test.

Q9 Chair: None of these people hold office indefinitely, so, as they are reappointed, presumably if

there was a fit-and-proper-person test introduced, it would be applied on reappointment.

Robert Francis: If I may say so, my idea of a fit-and-proper-person test is that it is a state, so it is something that is continuous, and the mere fact that you have a job does not mean you cannot be looked at for such things that you either do in that job or maybe have done in the past. The comparison is really with the fitness-to-practise test that the General Medical Council and Nursing and Midwifery Council have, which looks at past conduct in relation to its relevance to today's fitness.

Q10 Dr Wollaston: We accept that your inquiry was not a trial and that you found out more taking the approach you did. It is nevertheless surprising, isn't it—given that if hundreds of people died in any other organisation, such as the police or the prison service, we would expect somebody to take accountability for that—that no individuals have resigned as a result of this? In particular, do you feel that Sir David Nicholson should be considering his position?

Robert Francis: I have come here as the chairman of a public inquiry with a report that I have written and I have to stand or fall on the basis of what is written about individuals in that report. I have said and will say here that all individuals who are named in that report need to reflect on what is in the report and evidence a commitment in relation to the change of culture. But more than that I do not think it is appropriate for me to say about individuals. All I would say is that it is not accurate to say that no one has resigned. If you look at the foundation trust level, those who are principally responsible for the care of patients in that trust are no longer there. I have made comment about the circumstances in which some of those have left and that was the foundation for my recommendations in relation to fitness for office. But I do not think it is right for me to comment. It is not for an inquiry chairman to say what people should do following an inquiry. It is for them and those who employ them to consider the report, and, frankly, that sort of question should not be addressed to me; it should be addressed to them.

Dr Wollaston: Thank you.

Chair: They are coming.

Robert Francis: I thought they might be.

Q11 Rosie Cooper: Your inquiry looked at incidents that had taken place over a number of years and I would like to fast forward to evidence we heard in the last few weeks from the two lead nurses—one from the Department of Health and one from the National Commissioning Board. I had an exchange with Jane Cummings about the CQC report, which said that there were a fair number—I think it was 15 or 16, of that order—of hospitals where nursing was seriously understaffed. Weeks had passed since that report and I asked her what she had done. She indicated that she was the professional lead nurse and that she was waiting for reports. I pointed out that time had gone by and asked what action she had taken. I could not ascertain any action that she had actually taken, but what she did say was that the CQC would take action very quickly if there was—and these are her words—

“an absolute risk to patient care”. So from that exchange, to me, there appeared not to be any inclination for the National Commissioning Board's lead nurse to be accountable for the situation that pertained in those hospitals.

Recently, the Secretary of State Jeremy Hunt, I would suggest, has been seeking to distance himself as well because he admitted that politicians “on all sides have not been brave enough to speak out in the face of failure” and that the “deification” of the NHS may have led to the problems not being addressed. What we appear to have is the CQC as the back-stop. If the people now at the current helm of the NHS, the National Commissioning Board and the Secretary of State do not take the lead, what is going to happen? Who do you think should get a real grip of this situation now? If the professionals leading it and the lead politician are both talking a good game but the doing seems still to be missing, what would your opinion of that be?

Robert Francis: I did not hear that exchange, but I can say two things about staffing and the lessons I would seek to draw. First, where it is known that there is a shortage of staff, as there was at Mid Staffordshire, it is dangerous, putting it bluntly, to take a long time over the skill mix review and so on and then say, “Oh, well, we will implement the necessary changes in nursing staff gradually because of the financial considerations,” unless, while you are doing that, you make absolutely sure that you are delivering a safe service. That was one of the fundamental things that went wrong.

My recommendation for tackling that is, I am afraid, complicated, but anything to do with the NHS is complicated. I would like to see a simple and very clear set of fundamental minimum standards, which we all agree should never be breached, and if they are it is intolerable, and if it causes death it should lead to a criminal offence. But we need to be able to equip trusts with the information and the tools with which to make sure that they can comply with such exacting standards; well, they are not exacting standards—they are the absolute basic minimum. One of those is, “As a director of a trust, what staff do I need to run a cardiac unit or an old person's ward? What principles do I apply?” I heard that there are tools out there, but there seems to me to be no clarity at all which would help the director of a trust to know what the situation was on his wards.

As part of the background of guidance and a means of compliance, I have recommended that NICE should do work on this, not just in a generic sense, “You need x number of nurses in a hospital,” but, “How many nurses do you need on a day-to-day basis in an older person's ward or a surgical unit and so on?”, to be sufficiently clear that a member of a trust board will be able to say to the director of nursing, “How does this guidance work on our ward today?”, and they ought to know. One of the things with the trust was that they did not know—it took months to find out—how many nurses they actually had. So at this most basic level—

Q12 Chair: Presumably, they were paying them.

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Robert Francis: Yes, but the pay records did not quite equate with the nursing establishment figures, and it took the new person—a human resources director—a long time to work out how many nurses she had on her staff. That is how bad and difficult it is. At that level, it has to be got right and that is the way I would seek to do it.

As to the broader question, “Who is taking responsibility higher up the system?”, I have in my report commented on the move of the chief nursing officer to the National Commissioning Board and the director of nursing and public health in the Department of Health. All I have said about that is that I believe that that should be kept under review with regard to how effective that makes the voice of nursing at the centre of Government.

One of the crucial themes, I hope, of my report that comes through is the need to enhance what I have called the voice of nursing in all sorts of different ways. One of those, if I may say so, is the voice of nursing in, “How many nurses do you need to run an institution safely?” The senior nurse leaders in our country must be recognised as having an important role in that.

Q13 Rosie Cooper: Forgive me, Mr Francis, but while I absolutely accept everything you have just said—and I do—it is horrifying to have sat here a few weeks ago and had the lead nurse of the National Commissioning Board tell us that she did not believe in ratios, could not identify an action she took, except waiting for a report, and kept emphasising that she was the professional lead. As to this professional leadership, in an era of the CQC saying that hospitals are short of nurses, not physically going there and doing something to make certain of the things you have just spoken about, the people in the system—the public—will be horrified. How can a hospital not know how many nurses it has? How does the finance director—as the Chairman just said, they pay them—not know whether his books add up? You couldn’t run a shoe shop like this. So it is horrific. Do you believe—I think you have hinted at it—that we should establish minimum ratios of nurses to patients and that to breach that would be absolutely unacceptable?

Robert Francis: What I was told and accepted was that it is difficult and probably not helpful to have overall ratios and that is the standard you work to because circumstances change on a day-to-day basis. The needs on one day change according to the needs of the patient. Some places using different work systems may be able to do the job perfectly safely and effectively with fewer staff. So there is a range. What I thought is that, however difficult it is—I am not for a moment suggesting it is not—we should provide evidence-based guidance which allows trusts to know that, if they follow it, they will have sufficient nurses to provide safe and proper care in an individual clinical setting. The difficulty is that, if you have something that is too broad, it does not take account of the multiple different ways which the ingenuity of the medical profession finds to treat the same condition. To lay down in a regulation, “Thou shalt have N number of nurses per patient” is not the answer. The answer is, “How many patients do I need

today in this ward to treat these patients?” You need to start, frankly, from the patient, as you do with everything. “How many nurses or what proportion of a nurse do I need to treat Mrs Smith in bay 3?” You add up from that, it seems to me. But it may be, having done the work that I have suggested—and I really hope that that recommendation is taken on board—that you might end up eventually with a coherent formula that would work more universally. It did not seem to me, on the evidence that I heard, that we were there yet.

Chair: This is a subject Andrew wants to come in on.

Q14 Andrew George: Yes, it is. Our structure is slightly awry, but you don’t need to worry about that.

Robert Francis: I hope that is not my fault.

Andrew George: No, it is not your problem, but I wanted to telegraph that to our Chairman.

First of all, I want to come back to some of the broad-brush issues and then get back to the issue of staffing levels, if I may. Your report is excellent in identifying that in this case patient safety became subordinate to a preoccupation with tick-box targets and with making sure that the books balanced and so on, but of course the NHS also suffers from drowning in management babble as well. One of the difficulties I had in reading your report, if you don’t mind my saying so, is that there were a lot of unarguable concept phrases there about common values, fundamental standards, high levels of compliance, strong leadership, candour and compassion, and no one is suggesting or advocating that we should be doing the opposite—in a sense, you are pushing at open doors with entirely agreeable concepts.

When I was looking at the issue, something which is repeated through the report on many occasions—you repeated it again this morning—is that this should be founded on fundamental standards. I looked throughout the report—I have to say that I did not read every word, but I read quite a lot of them—and could not find any indication as to what those fundamental standards are. We can all agree that there should be fundamental standards, but can you give us any kind of indication? Give us some hard edges.

Robert Francis: I apologise for that. I do give what I consider to be some examples in the report. I am afraid off the top of my head I cannot tell you which page, but I will do so later, if you wish. In so far as I am non-specific about what those fundamental standards might be, that is for a very good reason. The reason is that in the past—it is a complaint I heard frequently at the inquiry—the standards that have been set for the CQC to regulate by, or before it the HCC, have, on the whole, either been set by Government and handed down, or at least, where there has been consultation and so on, it has been perceived by those in the system that that is the position and they have never been, in the jargon, “owned”. I utterly accept what you say about management babble, and I am sorry to hear you think I have adopted it, because I really tried not to in my report.

What we need is a set of standards that are the result of a consensus between the public who are being served and the professionals who have to provide the service according to these standards, and then

endorsed by Government. The sorts of things I have in mind on the page that I am talking about—I actually mentioned some of them this morning, and this is not drafted—are that it should be regulated that it is unacceptable that a patient should be left in filth; it should be unacceptable that a patient is left without food and water; and it is unacceptable that a patient should not receive medication that has been prescribed. I am talking about extraordinarily basic things of that nature which we would all think would be provided day in day out in our hospitals but manifestly were not on some, at least, of the wards of Stafford.

Q15 Chair: Can I be very clear about this? When you talk of minimum standards, are you talking about those kinds of standards from the patient's perspective?

Robert Francis: Yes.

Q16 Chair: So the patient knows whether the minimum standard has been observed or not.

Robert Francis: Yes, exactly.

Q17 Chair: You are not talking about NICE guidelines about how to deliver care.

Robert Francis: No. I have deliberately not used the word "minimum". What I am talking about as a standard I call a "fundamental standard", which is something that no sane person would ever accept not to be provided. If you have a minimum standard, a core standard, or whatever, I am afraid that evidence tends to suggest that that is what people work to and that is all they provide. I am talking about things that we used to assume were provided but we now know were not. They are things that a patient can recognise are not being provided, a member of staff there can recognise are not being provided, and, therefore, both can immediately take action to do something about it. My impression of the current standards regulated to by the Care Quality Commission is that it may be that the Care Quality Commission understands, by going round, whether there is a breach of them or not, but you or I wandering around a ward would not know. It is for that reason, rather strangely, although there are criminal offences theoretically involved in a breach of the regulations, that they can only be prosecuted if a warning notice has been served in advance. That means that some of the terrible things I have seen witnessed in the report about the care of patients could not be prosecuted as a breach of the regulations because there has been no warning notice.

Q18 Andrew George: I want to come back to the issue of registered nurse ratios. I totally agree with you that you should not adopt a one-size-fits-all approach for all the reasons you have explained. In terms of getting those minimum standards right and the priority of where the different standards might lie, if someone is lying in faeces, for example—which clearly is something which is unacceptable—but, on the other hand, there is another patient next door who is about to have an acute episode that might result in termination, clearly there is a priority there which a nurse needs to make a professional judgment about

taking action on, as to whether to clean up a patient or whether to save a life. You do accept that, in terms of the challenges that nurses face on a ward on a moment-by-moment, day-to-day basis?

Robert Francis: Yes, I do, but the way I deal with that is by saying in relation to an offence that there is a defence that it has to be reasonably practicable to do that. What I want to see is a circumstance where, if I take an illustration, if a nurse comes on duty and discovers that there are two nurses and 30 patients and they are all in desperate need, clearly she has to prioritise what she does, but she should not be put in that situation in relation to the compliance with fundamental standards. What she must do, and is under a duty to do, is to inform her management that this just cannot go on. If she does that, she has done all she possibly can. But has the management? Probably not, because they have not got the staffing right and they must do something about it. I want, through this, to ensure that those who are responsible professionally at the front line are not just left with nothing to do. I wish to see them empowered and encouraged to express a view because, by expressing the view, they are actually defending their own position. It is often said that the problem with serious sanctions is that it causes defensiveness. Let us use the defensiveness by ensuring that the responsibility gets to where it should be, which is where someone is capable of doing something about it.

Q19 Andrew George: Can I come back to the issue? I am glad we are on the nuts and bolts of the service itself. With regard to the media reporting of lack of compassion and almost incompetence of nursing, especially professionals, in the service itself, I want to be clear, in terms of your own mind having looked at it in such great detail, whether this was a case of quality or quantity of registered nurses, for example. Was it fundamentally the fact that the registered nurses and other staff were put in an impossible position, or was it because it just happens to be the coincidence of a particular group of rather incompetent and compassionless staff that happened to all arrive at one site at one particular moment in time?

Robert Francis: It is a combination of the two. We had, over a period of years, a growing and chronic staffing deficiency. Through that, I am afraid people are habituated to poor standards. But, in addition to that, there was clear evidence of some inexcusably callous treatment of patients, which had absolutely nothing to do with whether there were sufficient staff around or not, but simply, I am afraid, people who did not care. As to how individuals get to that stage, it is possible that some of them arrived in the profession like that, but, unhappily, it may be that morale deteriorated and people became like that. So it is a combination of those.

Chair: You can have one more go.

Q20 Andrew George: I want to be absolutely clear on this point, that you are saying that establishing registered nurse to patient ratios is something which is desirable, bearing in mind that you cannot establish a one-size-fits-all across the whole service. But having

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a mechanism by which—within your fundamental standards, I assume—that can be achieved is something you believe is the obvious outcome of your report.

Robert Francis: Can I deconstruct that slightly? The obvious thing is that on a day-in-day-out basis, the ward sister, the director of nursing or whoever else it is in a hospital, needs to know, “I have enough nursing staff of the right calibre on this ward to deal with the patients I have there today.” The board needs to know that is happening on a day-to-day basis. In order to do that, having a standard in my regulations, as I will propose, that says, “Thou must have X number of nurses” will not, in my view, work—certainly not on what we know at the moment. What we need is evidence-based guidance, which, if followed, would mean that the hospital would say, “We have done our level best to produce that and actually we do have enough staff” We then need to look, if that is the position, at why the individual nurses are not providing the work. Yes, you do need that.

Q21 Chair: If a fundamental standard is something that can be recognised by a patient, it cannot be “a number of nurses”, can it?

Robert Francis: No, except in the broadest possible way, which is not very helpful.

Q22 Barbara Keeley: To go back on this issue, it is very important that we are covering this ground and stressing this issue. Not only was it absolutely clear from the accounts of families in your report that the lack of nurses was such a critical issue—reports of hunting for a nurse for quite considerable periods of time, multiple buzzers ringing and totally being ignored, patients falling due to lack of assistance when they needed to use a commode, or whatever; that is there—but we are in a situation, as a Committee, where we have a situation across the piece where this is happening in more places than Mid Staffs. The CQC have reported that 17 hospitals currently have a dangerously low staffing ratio and that is affecting patient safety; and they have said that.

Unfortunately, though, there seems to be a view, which has already been touched on, of national nurse leadership that other things can come into play which negate this point about essential nurse staffing ratios. In fact, having put the questions that we did—I know you were not here, but it is important that we play out this argument—the answers we got back were something like, “It is not just about ratios; it is also about leadership,” as if somehow leadership could overcome this difficulty. I do not personally believe it can and I think it is absolutely important that we pin this one down. However good or compassionate and everything else that a nurse personally is, it is an impossible situation for them. It is almost as if they hid, from the descriptions that were around; I think they were pushed into a situation of not coping; they just were not around. It needs to be stated that this is something which cannot fall in this hospital, or other hospitals, to levels where an organisation like the CQC are saying, “It is dangerously low”, because it seems that nurse directors and nurse leadership, right up to the Commissioning Board level, are thinking

that this does not have to be the case and that there are other ways round it. Can I put that to you because that is what we are getting, both as Members of Parliament from Ministers and from nurse leaders in this Committee? It is very important that we pin this down.

Robert Francis: I agree entirely that you cannot provide a safe service, complying with anyone’s fundamental standards, unless you have sufficient staff to do it. A lack of that, by whatever means of judgment you have, is a very important danger signal that needs to be examined. However, leadership is also extremely important, whether you have the right number of staff, or particularly, frankly, if you do not have the right number of staff, it is the leader on the ward who should be banging the drum and saying, “I don’t have enough staff,” and, with their professional integrity and, dare I say it, courage, which is certainly necessary, saying, “We cannot do this, and I must report this wherever it is necessary to report.”

Can I make another point on leadership? Although you are of course right that in Stafford many of the problems may well have been attributable to the fact that there were not sufficient staff around, there was also evidence that such staff as were around would not be paying attention to any patient on the ward. There is, I am afraid, an element of that. That aspect, undoubtedly, is attributable to leadership. No ward sister on a busy ward should be allowing staff not to go and look at their patients. I would not wish my answer to be taken as meaning that nurse leadership is not important; it is absolutely vital, but, within itself, it is not the answer to issues concerning inadequate staffing levels.

Q23 Barbara Keeley: That is the view that seems to play back to us in this Committee and the House—that somehow, with adequate leadership or some other magic ingredient, you can get over issues of nurse-staff ratios.

Robert Francis: I can see that good leadership can make the work that the nurses do more efficient—for instance, which is a hypothetical example we are familiar with and have been hearing about it, stopping the nurses reading their magazines at the desk and getting them out working with the patients. Leadership is about producing effective work from the work force that you have. But if you assume that your nurses are working effectively and you still do not have enough staff to go round, then that is where you have the problem. I am afraid all these things are difficult and I am not going to pretend they are not, but it is a combination of having enough staff and the right leadership. One without the other is not sufficient.

Barbara Keeley: The point you made about the voice of nursing is very important, because our concern was that the voice of nursing did not seem overly bothered about this issue, and it is a very important issue, I think.

Q24 Chair: Can I be clear that when we talk of “fundamental standards”—again, I am picking up the points you made that this must be recognisable by the patient—the fundamental standard, as I hear what you

are saying, is that there should be adequate nurses, properly qualified, to discharge the function in the care environment rather than some kind of predetermined formula? Is that a correct summary of what you are saying or not?

Robert Francis: Not quite. My fundamental standards are, as you quite rightly say, the things that the patient, and indeed a member of staff, can recognise on the ward, and that is: is the patient being cleaned and are they being fed?—all those sorts of things. I am not going to prescribe that list because it can grow, but it has to be things that are achievable. In order to be achievable, of course you need the right staff to do it. I think putting a number on the staff in the regulations, or even saying that at that level of regulation you need adequate staffing, is maybe the wrong way to go, because the patients may not know what that answer is and the individual member of staff might not even know what that answer is. What we need is to make sure, through the guidance, the research and the evidence base that every board has a means of knowing whether, on a day-to-day basis, a ward is staffed. That is not quite the same as saying it is one of the fundamental standards. It is how you get to comply with the fundamental standards; it is how you deliver the fundamental standards.

Q25 Chair: The fundamental standard itself probably would not refer to it. It is a means of delivering the fundamental standard.

Robert Francis: I don't mind there being a regulation somewhere, as there is now, that says you have to have adequate staffing, but it does not do anyone any good.

Chair: Understood.

Q26 David Tredinnick: Looking ahead, what indicators would you use to identify the successful implementation of the cultural change that you are recommending in the NHS?

Robert Francis: That we stop hearing about patients being left in the condition that those in Stafford were left in; that, if it happened, we have heard that members of staff have spoken up about it; that, if it is impossible for the standards to be met, those in charge are honest about it and say, "We cannot provide this service," for whatever reason—money or whatever; and that the public are given open and honest information about the performance in every hospital. We have not talked about my other sort of standards, which are basically, I would suggest, a responsibility of those commissioning services—what we pay for in terms of the wider quality field. In relation to those, we need to have proper, informed information about how hospitals are doing against those sorts of standards, and we need the truth. At the moment, I am afraid we tend to get what the hospital board wants to tell us is good news rather than the bad. In broad terms, that is what we need. I could go on as I have five main heads about nursing and so on, and you have seen what they are. I would like to see those. Above all, we need openness, honesty, transparency and candour, because the rest almost invariably follows.

Q27 David Tredinnick: Moving on from that but related to it, you say that care workers were doing the system's business rather than focusing on the patient. You said that this morning. Do you suspect that this system's business rather than healthcare of patients is widespread across the health service and not something that you have just seen at this particular organisation?

Robert Francis: Because I have described it as a culture, and possibly an institutional culture, that must be the case. It is something that has to be guarded against continually because no one put the policies in place from either Government that we have looked at in order not to look after patients. That is what the purpose was. But those that do the work end up doing the job, not serving the patient. I do believe that means have to be found to put in front of every person in their mind every day the question of, "How is what I am doing impacting on patients?" If they can do it in a shop, I don't see why they cannot do it in the NHS.

Q28 David Tredinnick: So this mechanical process has spread across the service.

Robert Francis: Yes.

Q29 David Tredinnick: I put it to you that doctors, nurses and healthcare workers are not naturally uncaring. They all go into healthcare because of, very often, a vocation, because they love patients and want to dedicate their lives to patients. So we are talking about a systems failure here, which you have already alluded to, in the management structure. Crucially, how are you supposed to audit the quality of nurse and doctor care then? It is a qualitative thing. It is not necessarily something that you can put down in numbers, is it? How do you audit that?

Robert Francis: I am glad you mentioned numbers. I strongly believe—it is in answer to your question but it is also rather wider than that—that the statistics of performance are very important, but so much of what went wrong in Stafford, whether it was to do with an individual doctor or nurse or the system as a whole, could have been identified by just looking at the story of one patient. I can think of the one patient, and I will not name her—deceased as she is—here today. If you followed the experience of one patient from her arrival in hospital through to her death because she had not been given the medication that she was prescribed when she arrived, you would have seen a system at that hospital that was failing its patients. You need not one other case, but you needed to be told that story and its impact.

The same applies to the performance of individual doctors and nurses. In relation to appraisal processes for doctors at the moment—revalidation—they need to evidence, and I believe will, their ability to care for their patients; and I believe the same should be done for nurses. For that, I recommended that every patient should be, at any given time, the responsibility of an identifiable nurse and, indeed, an identifiable doctor, and we should be obtaining feedback from those patients, not necessarily at the bedside but when they have gone home, about that. You find out far more, I think, asking the patients once they have gone home with their families—hoping they do go home, or from

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their families perhaps if they have not—about individuals. That should be built into an appraisal and revalidation process. That would be one of my suggestions in that regard.

Q30 David Tredinnick: I have one last point to make. Listening to you and reading your report, to me, it is as if there has been a catastrophic failure to use information technology properly, either poor systems or an inability to access them and a lack of understanding of them. A lot of this patient information should be quantifiable in a proper IT system. Certainly, if I look at what the police have done in my county, in Leicestershire, they have improved their processes so much by knowing exactly where all their operatives are. They know where their cars and the police are—the different categories—and they can move them around. These models are available, and I would suggest to you that, apart from the qualitative aspect, the quantitative analysis is absolute rubbish and that is something that we really need to focus on.

Robert Francis: I have a number of recommendations to make about information. Some of them, I am afraid, necessarily are non-specific. It is absolutely vital, in my view, that we have open and comparable information about performance, in its widest sense, where it is relevant about individual surgeons, but certainly at team level and ward level. Information that is just about the hospital as a whole will conceal bad news in bits of it, and we need to show it in the wards. I have been to hospitals where they actually have on the wall in the ward that everyone can look at—if you can understand what is there—their performance on C. diff rates for the last month; they would have a red dot, which is bad news, for every single case of hospital-acquired infection on the ward in the last month and the last year. Compare that with the ward next door and on that measure you know which the best ward in the hospital is. We—the public—need to have that information; the regulators need to have it; and I would like to see a system, where it is relevant, that I can tap in on the website and find out what the rate of infection is on ward 11.

Q31 Valerie Vaz: That feeds quite nicely into the point I was going to make about this table of complaints. You could have in a redacted form the type of complaints or concerns that are coming through that should really be made public.

Robert Francis: Yes. That is certainly my view and I hope it is expressed clearly in the report. We need to use the information that we get from complaints far more broadly than we do. In Stafford, unhappily, even the board was not receiving information of that level because they considered that an operational detail, which is, in my view, inexcusable.

The information from complaints, the story that each complaint tells, should be available to commissioners, who, after all, are paying for the service on the public's behalf and therefore need to know this information. Having high-level figures that lump all complaints about clinical care into one category is not very helpful, frankly. There is an issue about the numbers of complaints and how you handle the telling

of the stories, but they should be available. You can see a lot of complaints now if you look on the various websites that publish them. That is an incredibly powerful tool, in my view, if it is developed further.

Q32 Valerie Vaz: Having heard from various bodies in the NHS, which one do you think would be the best to co-ordinate best practice level of complaints?

Robert Francis: The healthcare systems regulator needs to have a role—I emphasise not in terms of being a tier of processing of the complaints but simply in terms of the information you get out of complaints. That needs to be an integral part of the information they have, possibly within their quality risk profile. Because there are so many, clearly the significance of that needs to be assessed at a local level rather than on a national basis. That would be one source. But it is an area where we need more than one lot of people looking at it, if I may say so.

The people most intimately involved and responsible, in my view, for checking whether a proper service is being provided as commissioned must be the commissioners. I am anxious that if that is the system we have—and there is an argument to be had about that, fortunately not for me to have an opinion on—if we have commissioners who are buying services, then they must have the means to check that those services have been delivered according to the specification that they have agreed with the relevant trust. That needs, obviously, national co-ordination through the Commissioning Board, and individual groups need support, but it is a vital part of what they do. They would find out far more from that than looking at throughput figures and all the rest of it, in my view.

Chair: I want to bring in Grahame, who has been very patient, on duty of candour, and then go to Andrew.

Q33 Grahame M. Morris: You have covered a lot of ground and there are a couple of examples relating to what you have said previously on a ward setting about how important it is to have a duty of candour and what lessons we are learning from the Francis report going forward so that these situations do not happen in the future. I am aware of a very recent example, after the publication of your report, relating to the Yorkshire Ambulance Service, where staff have raised concerns about proposals by management to deskill the paramedics and have emergency care assistants. The response of management has been to de-recognise the trade union that raised those concerns. How do you feel about that?

Robert Francis: It sounds like a matter of concern, but obviously I cannot say really. But—

Q34 Grahame M. Morris: It is absolutely outrageous, isn't it?

Robert Francis: An essential part of what I am seeking to get over in my report is that there should be no obstruction to individuals, or groups of individuals, raising honestly held concerns about patient safety. Those need to be listened to. If there is to be a penalty, it should be to penalise those that do not exercise their responsibility to raise those things, not the other way round. It is why I have recommended within the hospital setting that it should be a criminal offence to

deliberately obstruct the reporting of information. I have recommended that what are commonly called “gagging clauses”—I have been corrected and told they should be properly called “non-disparagement clauses”—should be banned, certainly in relation to patient safety. I can quite see there is a case for clauses preventing people being gratuitously rude to colleagues, or whatever, but this is far more serious than that. There needs to be full protection for people who genuinely raise concerns rather than the extremely complex system we have at the moment. If we did that, we would not have to be talking about whistleblowers. We could talk about everybody contributing to a safe system and being welcomed for so doing.

Q35 Grahame M. Morris: Can I ask a short supplementary? Within the context of the inquiry, because you had fairly strict terms of reference, is the environment in which healthcare is now being delivered—in the context of the Government’s changes and NHS reforms, the financial pressures that are affecting ambulance services and hospital-based services—a factor in how these situations are developing?

Robert Francis: In times of economic challenge, it must be even more important to protect patients and their safety by ensuring that there is openness and honesty in the system, and by that I mean that there is genuine honesty about what can and cannot be done. The reason I have concentrated on—I am sorry to go back to it—the fundamental standard is that the very least we can expect of a national health service is that those who run it, at any level, tell us when something cannot be done safely and, therefore, we can no longer do it, and to re-order whatever the service is accordingly.

There is no point in us providing a service to patients that does them harm, which is a grim truth, and it is awful to have to say it. So we need to provide a service that does not do that, and, if we cannot do that, we need to think again.

Q36 Chair: Did you have a go at drafting what you meant by a statutory duty of candour? You mentioned that there is always a tension in this subject between wanting to encourage an open culture, for all the reasons you have identified and I agree with, and score settling between individuals who have private agendas. Who should be subject to a statutory duty of candour and how should the duty be formulated?

Robert Francis: It seems to me that one of the problems with this area is that there is a little bit of confusion often in what we mean by a duty of candour. Conventionally, the discussion has been in terms of candour about honesty to the patient, in telling a patient who has been harmed or might have been harmed by care the truth about that. There is a wider field of candour, which I distinguish by calling it “openness and transparency”, which is about the truth as to more general information concerning the service.

In relation to candour to the patient we already have a professional obligation, in their codes of conduct, on the part of doctors and nurses to be honest with

patients. What we lack, except by means of guidance, is an obligation on the part of organisations to be honest with patients. First, the organisation must have that responsibility, and, in practical terms, it is the organisation that needs to organise the telling of the patients quite a lot of the time.

I believe that, therefore, there should be a statutory duty on the part of the organisation where a patient has been harmed or may have been harmed by the care provided to tell the patient that, whether they have asked questions about it or not, and that should be a statutory duty. The reason I think it should be a statutory duty is that it is all very well having a contractual obligation to a commissioner, but the reality is that the obligation is to the patient. There needs to be that direct relationship, which needs to be recognised and, dare I say it, it follows that there will be a remedy involved if that was breached in itself. So there is that duty enforced by a sanction, which means that anyone who gets in the way of that duty deliberately should be subject to criminal sanction.

The reason I have come to this view is that, you will see, I have spent quite a lot of time in the report describing certain incidents at Stafford where important information, in my view, was withheld from relatives of a deceased patient because it was believed—honestly believed—by those doing it that it was in the trust’s best interests to do that, which is, I am afraid, not a happy story for my profession. That is the defensive culture that has grown up and it needs to be changed. That is my duty of candour.

I have other duties that I suggest in relation to openness and honesty about information, which require honesty and balance in what is put forward. Does that answer your question?

Chair: In general terms, yes.

Q37 Grahame M. Morris: Is there enough protection for whistleblowers who raise concerns? If there is not, how would you strengthen it, over and above the kind of case—

Robert Francis: It has been remarked that I have not made any recommendations specifically called “whistleblowers”. That is because the problem is wider than that. Whatever legislation you have about whistleblowers, so-called, it will not in itself stop the sorts of things that the Stafford whistleblowers had to put up with from their colleagues, so-called, in the ward. It may help you at an employment tribunal later down the line, but it does not help you at the time. What we have to do is to find a means of making it the normal thing to do to raise concerns about what is going on in the hospital and, if necessary, about colleagues. The way you do that is by making it more difficult not to do that than it is to do it. I know that sounds slightly counterintuitive, but we need encouragement, I am afraid, for people to take their courage and to make it their obligation so that they have at least the protection, and can say to their colleague, “I am frightfully sorry but I had to do this because if I didn’t I could be prosecuted.” That is a pretty good start when talking to your colleagues. I believe, although it may, when you first think about it, sound paradoxical, that it will encourage openness

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as the norm at a stage before you need to talk about whistleblowers.

Q38 Chair: That applies in cases where somebody has broken or is suspected to have broken a criminal law. It applies also, does it not, if they had not complied with good professional practice—

Robert Francis: I think that is right, yes.

Q39 Chair:—and where prosecution does not arise but question marks over registration might.

Robert Francis: Yes, and it does—

Chair: I was picking up your word “prosecution”; that is all.

Robert Francis: Yes, I am sorry. It is often said that people will become more and more defensive, but that has not been seen as a reason for codes of conduct, which could lead to being struck off if you do not do it, saying, “You must disclose concerns about colleagues.” The extent to which it happens is questionable, but I think it is happening more, anecdotally, than perhaps it used to.

Q40 Chair: But not enough.

Robert Francis: Not enough. The point here, I think, is largely that people faced with impossible conditions on a ward have not done anything about it or have been put off doing something about it. At Stafford—and I have said this in the report—the medical profession on the whole must have looked the other way or not paid attention or whatever. It is difficult. Someone asked earlier about people being held to account. It is rather difficult to identify individuals about this, but collectively—and there was some graphic evidence about it—people were admitting, “We kept our heads down for a quiet life,” and that has to change.

Q41 Andrew George: The culture of fear, which you clearly identified and was played out rather well in the very compelling evidence from Helen Donnelly on page 1502 onwards in the report, demonstrates some of the perhaps quieter pressures that are put on staff. While there may be a duty of candour, that candour can be career limiting. You are not necessarily going to be fired on the spot, but the pressures are clearly there. I know from some staff that I have spoken to—I know that this appears to come out in the report itself as well and I would like your comments on it—that dynamics of leadership, which you say is really very important, and candour in fact can push in the opposite direction. In other words, what is often said by leaders on wards and by leaders speaking to the sisters and matrons on wards is, “Well, your colleagues seemed to be able to manage with that level of staffing. Why can’t you?” It is that kind of level of pressure, the questioning of competence of someone, why they cannot manage with threadbare staff when others can. Do you not see that there are two pressures working in opposite directions here?

Robert Francis: Of course there are and it is impossible to legislate entirely in relation to what, at the end of the day, will sometimes be a genuine matter of opinion. That is difficult. But it does seem to me

that we can do something about the gross and appalling behaviour that, for instance, nurse Donnelly was subjected to by colleagues. It is the human reality, probably even in the best run of hospitals in the most general sense, that, unfortunately, it is the reaction of colleagues who are perhaps guilty of poor practice to seek to defend themselves and they will defend themselves in that way, which is why we need to change the culture so that the momentum of people who talk openly about these things and raise the concerns defeats those who are promoting the more negative culture.

I regret to tell you that, in my view, legislation in itself is not going to solve that. It has to be done through changing behaviour by leadership, by example. By that, I mean that you have a chief executive who visibly welcomes and supports those who come to him with unwelcome news, even if he does not agree with it—and I think this is the important point—the divisional manager does the same thing, the ward sister is heard to listen to worries of her staff, even if she does not agree with them, and they then have to explain to these people who have made the complaint why that is the position.

I heard something very compelling—it was not evidence because it was at the seminar—from a chief executive dealing with nuclear safety. He was absolutely adamant that the way in which you encourage this is personally to be talking to people, and, when they tell you something which you do not really want to hear, you thank them for it and recognise them for that, and then, if you disagree with it, you explain to them in unthreatening terms why it is you disagree with them and you hope to persuade them. If you do not persuade your staff, you are not leading them. That is why leadership is so important and that is one of the reasons I want to train leaders in this sort of thing.

Q42 Andrew George: But those leaders need to listen and take action. In terms of the practical outcomes of the complaints that were raised by Helen Donnelly, one was that nurse preceptors were thrown straight into the deep end on an A and E unit, whereas years ago they would have had a year of being effectively supernumerary, or thereabouts, on wards. Surely that should be one recommendation—that we should have a system whereby, for the first year or the six months that nurses come straight out of training, they should not be subjected to working entirely on their own in circumstances like that. That was a proper complaint, which needed some action and should never happen, surely.

The other complaint is that, while you have shied away from saying that we should prescribe registered nurse-to-patient ratios, should it not in any case be a benchmark? Should we not have some kind of clear national guidance that would give people at least some indication of a certain level of acuity, a certain specialty or on certain types of wards that you should have certain levels of staff?

Robert Francis: I have not shied away from that, with respect, because I am suggesting that we get the best evidence we can from the experts in all the various fields as to what it is that you need to run a particular

activity safely and, if that is not happening, then questions can be asked. All I am suggesting, for the reasons I have mentioned, is that that is not your fundamental standard as such because that should be about what is delivered. The number of staff you have is how you deliver it. To have an overall ratio that says you must have x number of people in the hospital is not terribly helpful because you would have so many exceptions to it that it would become meaningless.

Chair: You might not agree with it, Andrew, but I think we have covered that.

Q43 Valerie Vaz: I want to come back to your point. I have heard evidence from people, from the professionals, to say that when they have raised issues it is the management that told them to be quiet and actually have made their life a misery. They can organise, sometimes, evidence where the doctor or the nurse is removed from their post. Other than your code of conduct for managers, what else would you propose for management accountability?

Robert Francis: First, we need much more active clinical engagement by the healthcare professionals in management. It is a distinctive fact about Stafford that, for all sorts of reasons—demoralisation among them—clinical staff did not come forward in relation to taking on these posts. Their voice was not heard. We have somewhat disempowered clinicians who actually understand these things in favour of managers who are more likely to do the system's business. What I am trying to do via the recommendations in so far as managers are not clinically qualified is to see that they are trained in a form of ethics that is comparable to that, so that they all have the patient's interests first. That may sound wishy-washy, but it is not when you ally it to having accountable directors, who could be, in effect, disciplined by being found unfit and not proper people for the job, because it is their responsibility to ensure that their management act according to the core values that we all agree should be in place. I have said that we should keep under review whether a wider disciplinary system is needed for managers as a whole. The reason I have not said to go for that now is, first, I think you need an evidence base for that, which you could develop over a period of time, and, secondly, it might be thought that now is not the appropriate time to be recommending yet another organisation regulator to be set up.

Q44 Rosie Cooper: I wonder whether you would comment on the duty of candour for an individual as opposed to the legal advice that individual would also get and the conflict that a lot of people find themselves in.

Robert Francis: Do you mean the legal advice that "You are less likely to get into trouble if you keep your head down"? I don't understand what you mean by "legal advice".

Q45 Rosie Cooper: Forgive me. As a former chair of a hospital, it was very difficult to get doctors—not just doctors but clinicians as well—to come forward and be open and honest about what had happened and

examine an incident, when at the same time the legal advice they would be receiving would tell them to take a different view. A clinician in a situation would have, yes, a duty of candour, but also not just defensiveness but that self-protection and the legal opinion that would come to him or her, as the case may be.

Robert Francis: I think it was Sir Ian Kennedy at my inquiry who said that the offence of not owning up to the mistake should be regarded as more serious than the mistake itself. I have not quoted him exactly. I would agree with that. We need to put into the system that recognition.

How one does that is, first, through all the things that are wrapped up in the management term "clinical governance", which you will be familiar with, but in terms of ensuring audit, clinical audit, appraisal and so on, so that there is open acknowledgment in a practical way of things that go wrong. Of course the doctor is faced sometimes with the fact that what he has done might expose him to a charge of professional misconduct of one sort or the other, or, under some of my proposals, possibly the theory of a criminal sanction. I think it is necessary to recognise that, where unfortunate things have happened, it is much more important that we get the truth as to what has happened and produce the remedy for the patient and learning. Therefore, a failure to take those steps should be regarded as much more serious than what happened originally—in most cases.

Some cases are gross and you are never going to legislate those out of the window, but the approach, for instance—I know this from my own practice of the Professional Conduct Committee, and it is not called that now—at the General Medical Council is that they will look much more favourably at individuals with regard to their continuing fitness to practise if they show insight into what has happened, they have reflected on it and they have done all they can to remedy the situation, rather than the man or woman who continues to deny that anything ever went wrong. That is all one can say about that. We need a situation where the legal advice is going to be, "I know this is unfortunate, but you are going to be better off by telling them about it and being honest and open about it than not."

Q46 Chair: It is one of the complexities, is it not, of introducing the concept of the criminal law into that debate? I am not a lawyer, but as I understand it, it is an old principle of criminal law that you cannot be required to give evidence against yourself. That is, in some circumstances, precisely what you are required to do by professional obligation.

Robert Francis: The prosecution discretion is undertaken by the Care Quality Commission, not the police, in the matters I am talking about. I think they would be able to take that into account as a matter of discretion whether or not to prosecute. If there is a duty of candour and it is a criminal offence to obstruct that, then that is what I would suggest prevails. At the end of the day it is a matter of drafting, I believe.

Q47 Barbara Keeley: One of the key issues is the gaps between the functions of the different regulators,

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and obviously the situation where Monitor was authorising foundation trust status but ignoring serious concerns that the Healthcare Commission had found about the trust. Could you tell us—because there have been varying reports—what you propose about the future of Monitor and the Care Quality Commission, because you said there should be a single owner of quality, and that is understandable? But you have also said that there should be no temptation to introduce new regulatory bodies to replace the CQC and, generally, you have talked of avoiding further system reorganisation. What is your proposal about those two bodies?

Robert Francis: My proposal is that one regulator, in assessing the safety of the hospital or the compliance with standards of the hospital, should be considering both what have up to now been called the quality outcomes but also the financial corporate governance that makes that compliance possible under one roof. That is not to say that the expertise that Monitor have in relation to looking at those matters is not absolutely valid—it is—but what we saw here was that dealing with them separately, under separate organisations, meant that one did not talk to the other. It might be said, “You can sort that out by getting one to talk to the other,” but I think you need the teams who do these things to be working together so that the perspective of each in the course of their investigations and so on feeds off each other so that we no longer have the issues of corporate governance being dealt with without people thinking to themselves, “How is this in itself impacting on patient safety?”

Therefore, I would envisage initially much the same people who do this in Monitor continuing to do it. It is simply that I believe they ought to have the same boss, if you like. I have not suggested one way or the other whether that means you get rid of Monitor or you amalgamate them, because there are other functions that Monitor perform. I see this as—and I said it should be—an evolutionary process because we have to keep such regulations as we have going while we do this. The operational implementation of that is something that I do not feel qualified to go into. That would require another volume of a report, no doubt. But the important point is simply that this should be work that is done together for the benefit of patients rather than separating off the system bit from the outcome bit.

Q48 Barbara Keeley: It is initially working together and possibly a merger.

Robert Francis: Yes, and working together pretty soon, frankly.

Q49 Barbara Keeley: Straight away.

Robert Francis: The relations between the organisations were characterised at the time we are talking about by, putting it bluntly, boundary disputes that should not have happened. If you have separate organisations in separate buildings, separate offices, you are bound to have practical communication difficulties of the sort we saw here. There was an attempt, at low level, of communication between the two but it never got anywhere. If you actually say,

“We are investigating Stafford”—or wherever it is—and you put your whole team on it, in one organisation it is much easier to do that. I know it is a simple point to say; it is more difficult to put it into force, but it is a vital one given what we saw happen about Stafford.

Q50 Chair: That is very helpful because one of the headlines that came out of your report last week is that “Francis recommends the merger of Monitor and CQC”—and that is in fact not what you are saying.

Robert Francis: No, it is not what I am saying. If you like, it is a merger of particular functions under one roof. One function of Monitor, at least in theory, is of diminishing volume because, in theory, if everyone becomes a foundation trust this aspect has gone. But the function of continual regulation remains.

The other important point is that the powers that Monitor has in terms of intervention are powers, it seems to me, that arise as much out of failures in relation to CQC’s outcomes as they do elsewhere. There is something slightly odd, I think, in having a different lot of people making the judgment about what intervention is needed than the people who are finding out what is wrong. We had that with Stafford because the healthcare commission was reporting on things that were going wrong; Monitor was hearing about that, but it was making the judgment. Then you had the assumption in the system, which we have seen too often, that all this is someone else’s responsibility until later.

Q51 Chair: It is something we have commented on in our recent report on the CQC. There needs to be a clearer understanding of who is responsible for what between the two. But, at the other extreme in Monitor, there is the issue of the responsibilities of the Co-operation and Competition Panel—nothing to do with the CQC.

Robert Francis: That is nothing to do with the CQC.

Chair: That is helpful; thank you very much.

Chris, do you want to go back? There is a certain amount of confusion because we have missed out a page; apologies.

Q52 Chris Skidmore: In many ways, if it was not for Julie Bailey in the Cure the NHS campaign, Mr Francis, you may not be here in front of this Committee today.

Robert Francis: No.

Chris Skidmore: And a thousand people would have been buried without any notice being paid whatsoever to the appalling standards of care that were missed by the strategic health authority, the Department, Monitor, the Litigation Authority and the scrutiny committees.

Reading your report, for me—although obviously the evidence is horrendous and appalling—probably one of the most damning passages was on page 1312 of volume 2, which referred to a meeting that took place between Sir David Nicholson and Ian Kennedy on 14 May 2008, at which point Sir David warned Sir Ian Kennedy of the Healthcare Commission that the local campaign group had been in existence in Mid Staffordshire for some time and clearly patients needed to express their views, but he hoped the

Healthcare Commission would remain alive to something that was simply lobbying or a campaign, as opposed to widespread concern. You have talked about—

Robert Francis: Can I say something about that passage, in fairness? I considered the evidence surrounding that and the conclusion I came to—Sir David denied that that was said and the person, it was Anna Walker, I think, from memory, who wrote that—

Q53 Chris Skidmore: You said he could not recollect it, which is distinct from a denial.

Robert Francis: I could not be satisfied that that was what was said, so that was my finding of fact.

Q54 Chris Skidmore: But in terms of a defence—

Robert Francis: I did say that if it had been said it would not have been acceptable, and those are not my words in the report.

Q55 Chris Skidmore: Does that not go to the heart of what is essentially, as you said, a defensive culture here? If we are going to have an NHS—in many ways, the sound of your report slamming down on to the desks to replace the bedpan rattling through the corridors is a seismic moment for the NHS—we have to put patients and patient groups at the centre of concerns. Given the fact that Cure the NHS went for so long without their concerns being recognised, how do you feel the patient groups should be accepted within a new NHS structure?

Robert Francis: First, can I absolutely accept the importance of the role of Cure the NHS in this story and the help they gave my two inquiries? The patient voice is absolutely vital, whether it is an individual or a collection of people. If only more time was spent by all listening to what the individual patients have to tell them, many of these things would never come about. What I have suggested is that there should be far more integration of what I would call loosely the patient point of view at all levels of the system. I have suggested there should be patient involvement in commissioning groups; there should be patient involvement in the Care Quality Commission; there should be far more contact between people in the Department of Health and, put it this way, real patients, rather than talking between managers. How you do that is, I accept, a challenge, and there is a reason for this. Patients and the lay public in general are excellent sources of information about what they want, what their experience has been and their feelings about that. That is information which should inform the service that is provided. We need patients in all these places.

What the patients—and I am sure you would agree—are less able to do is to come up with the solutions. If you take Julie Bailey as an example, she quite properly, in my view, refused to get involved in the trust. She was complaining about it and wanted them to hear what she had to say, but, when they invited her to come inside the tent, she refused to do so because she said, “That’s not my job,” if I can paraphrase it, and I understand that position. It is, in a sense, the role of the patient and patient groups to say what they want, say what their experience is and

what they would like done about it. It is the responsibility of the service to respond to that and deal with it. So that is the model.

I have in my report been less than complimentary about the patient involvement schemes—and their effect at Stafford at least—over the years that we were looking at. I was and still am not able to comment on the effectiveness or otherwise of their replacement, but what is absolutely vital is that it is not sufficient to create a structure in which you put patients in a room, provide something loosely called “administrative support” and expect that to become meaningful and effective. If you are to have patient groups of this nature, they need proper support so that the issues that they raise can be translated into something that is going to have an effect in the health service. Individuals themselves are never going to be able to do that.

Q56 Chris Skidmore: Just on that issue, do you think that the Government’s new friends and family test is in itself sufficient? Do you think, referring to what you have just said, that it will need to be backed up?

Robert Francis: I don’t know enough about what is meant by the friends and family test to know, but what I can say is what I think is required, and then perhaps it is for others to see whether that fits it. We need as many forms of feedback from patients as we can—and staff of course, but I am dealing specifically with patients and their families. It is absolutely right that one should try and collect feedback while patients are in hospital, but we all know that many people are very reluctant to raise concerns while they are sitting in a hospital bed, for reasons that are obvious and we do not need to go into. We need to follow up what patients thought about their care once they have gone home. It happens only too frequently, in my experience, when I have been to a hotel, or whatever it is, that someone is following it up.

A very simple thing—and I know it is not possible or practical in all cases—that occurs to me is to wonder why it is that after a patient has gone home the sister of the ward does not pick up the phone and ask someone how they are getting on. That is just a simple service element. But there should be a more systematic way in which we ask patients who have gone home to say what their experience was like rather than waiting for them to complain. A lot of people would like to raise a concern but not complain. The system should listen to the concern with as much seriousness as they listen to the formal complaint. My experience in a lot of fields is, “Don’t look at the compliments”—which you always will get, quite rightly most of the time—“but look at the concerns,” which may be a small minority, but that little minority tells you much more about what you need to do than all the compliments in the world.

Q57 Grahame M. Morris: While we are covering this area, what are your thoughts about the proposal by the Prime Minister to create an inspector general of hospitals, sitting within the CQC presumably?

Robert Francis: Again, my conclusion was that, in terms of regulating hospitals, the most effective means

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demonstrated, and therefore one that should be continued, was in physical inspection of hospitals by trained and experienced hospital inspectors. My recommendation was that the Care Quality Commission should consider developing a team of such hospital inspectors. If the concept of a Chief Inspector of Hospitals does that, then all well and good, but at the moment all I have is a headline.

Q58 Dr Wollaston: Can I come back to the subject of regulators? I am wondering whether you feel that regulators like the GMC and the NMC should be far more responsive to situations such as occurred at Mid Staffs.

Robert Francis: Yes is the simple answer. I have said they should be more responsive by way of not just sitting back waiting for a complaint to come in—and, of course, they must react to complaints—but, where they become aware, as they will do, of concerns about a system, they should be alert to considering proactively whether those deficiencies, which are being brought to light or of which they are made aware of, are due to a failing on the part of someone who is accountable to them and a breach of whatever their code of conduct is. That, I think, requires a different approach from the one that they have been undertaking to date. It requires in real life, I am sure, much closer co-operation with the systems regulator and possibly joining them in their investigations so that, if an investigation is taking place of a particular place, the professional regulators are involved in that.

Q59 Dr Wollaston: Further to that, there is another whole separate category of healthcare workers who are not registered at all, and you refer to them in your report; that is healthcare assistants.

Robert Francis: Yes.

Dr Wollaston: And there is the wider area of the training and continuing professional development that is available to healthcare assistants. The Government have indicated that they are more minded to have a system that looks at barring those who are unsuitable. Do you think we should go further than that and make sure that it is a much more positive process—that all healthcare assistants are registered?

Robert Francis: My view expressed in the report is that there should be a registration system. The reason I say that is the very basic point that it seems to me that someone who is allowed to undertake direct physical care of any patient, let alone highly vulnerable people who cannot even speak for themselves, should be the subject of at least some record of who they are, where you can get hold of them, where they are employed and, if they are no longer there, why they are not there anymore.

I make the point in the report that it seems strange to me that there is more regulation for nightclub doormen and minicab drivers than there is for healthcare support workers. The fear expressed sometimes about registration is that you bring with it a whole raft of complications with regard to qualifications to be on the register. I am afraid I don't see that. It seems to me that, if you are employed in a post that comes within the definition for which registration is required, you get registered. Then, if

you are registered, you have to be registered in order to do the job. It could start as a formality, but what it means is that there is a means of getting hold of this individual, and where they are found to be unfit or unsafe to leave with patients we know about that, or, most importantly, another employer can get to know about it.

At one end of the spectrum you could set up, or charge a regulator to set up, an entire disciplinary system to deal with that. But I believe that you could also have a simpler system that involves allowing employment contracts to rule, so if an employer dismisses the unfit person they are then obliged to tell the register about that and that information is then available to another employer—I think probably not, in that instance, to the public because there would not have been the right form of due process. At the moment, quite literally, a healthcare assistant who is found totally unfit in one hospital can walk down the road and get a job in another, and one does not need to know about what happens in the other place.

Q60 Dr Wollaston: Can I go back to that? One of the other issues here is the wider impact of your report on the social care system. Many healthcare workers might go out and directly be employed by a very vulnerable individual in their own home. If we did not have a system of transparency, how would family members, perhaps employing someone to look after a very vulnerable relative, know? Why should they not have the right to access such a list?

Robert Francis: There is a great deal of force in what you say. I recognise in the report that what I have to say in terms of its implementation needs to take account of the fact that the healthcare workers work in the private sector as well, and my report has only been about the hospital service as such. But you asked me the question and I will give you the answer. I see no reason why such a register should not be accessible, or the information on it, to someone who is contemplating employing someone privately. We have a system of CRB checks, and I have no idea whether it works in that regard for healthcare support workers—probably not—but there is no reason why one should not have a system where, for good reason, you can access that part of the register.

The alternative, if that is not going to work, is to have a more developed disciplinary system, which would have tribunals of the type that exist for qualified nurses. But I do recognise the numbers involved here are such that you might want to start on a more modest base and see how that works before moving to something else. Of course, I recognise it does require legislation.

Q61 Dr Wollaston: Would you anticipate that this role would be best undertaken by the NMC or do you think it should be entirely separate from the NMC? Have you made any assessment of what kind of extra resources that would require for the NMC?

Robert Francis: I have suggested that the logical place to put this would be in the NMC because of the overlap between qualified nursing and this category of worker. Of course, many committed and caring healthcare support workers start off that way and then

become qualified nurses, so there is an interaction there.

As far as resources are concerned, we looked at how much, currently, a nurse is charged for being registered on the register, and I have now forgotten what the figure is, but it is about £100 or £120, something of that order. I know there are issues about the resources of that organisation, but that sum covers the cost by and large of the much more complicated system that is required for registering and disciplining nurses. So, whatever the figure is for healthcare support workers, and bearing in mind the bulk of numbers involved, I would envisage something very much smaller than that. That is the scale of what we are talking about.

Q62 Dr Wollaston: My final question is about the actual training and continuing professional development of healthcare support workers. Could you elaborate further on that and say what further resources you think should be available for continuing professional development?

Robert Francis: The level of training required is different from that required for a qualified nurse, for all sorts of reasons, but I was concerned to find that there seemed to be no consistency at all about the training required for this grade of worker. In a lot of cases the amount of training before they are let loose on patients, if I can put it that way, can be as little as a few hours. I don't think that that gives anything like sufficient recognition to the difficult and valuable job that these people do.

Everyone talks about basic care as if it is easy. The respect that is due to people who undertake this work, in my view, is absolutely immense, and they get too little of that. Therefore, we need some training standards. They do not need to be very complicated, but I emphasise two things. First, we need to test people's aptitude, both for this sort of work and also to become nurses, and, secondly, we need to test their aptitude not just for any technical skills but also for their attitude and their commitment. These are difficult and sound like woolly concepts, but they are extremely valuable and we all know, I am sure, from interviewing people how you can judge these things.

We need recruitment for that, but we also need to train people, whether on the job or not, about what it means to provide a compassionate and caring service to patients. Frankly, in the hospitals I have been round as a result of this inquiry, you immediately see how some people do it and some people do not. However caring you are, you need to be trained, I think, to know how you are caring in these very difficult circumstances that they have to deal with. We need training standards, recruitment involving values and we need to instil those values, both at the beginning but also throughout their actual work in this job.

Q63 Chair: That commitment to training, which I think is very broadly shared, raises the question immediately, doesn't it, whether you link the successful completion of that training process with registration for healthcare assistants?

Robert Francis: Yes.

Q64 Chair: Your version of registration, as you described it a moment ago, divorced the two and said that registration was purely a question of knowing who we are talking about.

Robert Francis: There are obviously stages in this, and if you are starting at a stage where you have no consistent training standards, no mechanism to deliver those, then you have to recognise that. It seems to me you have to start, if you are selected to be employed by someone who is providing this particular type of service, by being on the register, and if you are on the register you can be disqualified from it. That seems to me the very basic minimum. You can develop from that, but, as to whether you need to, you need to see first whether the minimum suggestion works better than what we have at the moment.

Q65 Chair: There is a school of thought that we need to make more registration effective for some of the more advanced professions.

Robert Francis: There is that; I understand that point of view.

Q66 Chair: Can I come back to where Sarah started, which was on the implications of this report for the GMC and the NMC, with its current scope of responsibility and what could, in principle, be a recommendation with huge implications for those organisations, that they need to move beyond reacting to cases of professional malpractice towards being a more engaged, proactive regulator of the provision of care, with the implied requirement on both of those organisations to provide themselves with a sufficient flow of information to allow them to carry out that function effectively? I wonder in how much detail you have thought through the implication of that.

Robert Francis: In a well-functioning system of regulation—and I appreciate there is a large “if” in that—if you have that, then a lot of the systems information should already exist in that which is collected by the Care Quality Commission. We heard lots of evidence about the quality risk profile and the intelligence that lies behind that and—[*Interruption.*]

Chair: That is a tribal signal.

Robert Francis: I understand that. Do you mind if I wait?

Chair: You will find that it will start again in a couple of minutes; they are praying now.

Robert Francis: I am afraid it has completely distracted me from where I was. The Care Quality Commission and the quality risk profile: there is a huge amount of information already being collected for that, and I have made suggestions as to areas where they may collect further information into that. What I am really suggesting is that the professional regulator should plug in to the information that is already available.

Q67 Chair: But it is quite a big leap, isn't it, to go from where they are now to plugging in to that information and, by implication, possibly—this is a question—themselves initiating inquiries on the basis of that information without any case having been brought to them by an injured party?

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Robert Francis: If there are concerns about systemic deficiencies of this nature, you would expect, in a system that was being run properly, that the Care Quality Commission itself would have detected that or the cause for concern and be investigating it. What the General Medical Council, the Nursing and Midwifery Council or whoever could bring to that process would be the necessary input to say, “While we are looking at that, there seems to be a problem. You are telling us there is a problem in the surgical division. We have had a peer-review report of a dysfunctional surgical division.” In my experience, a dysfunctional surgical division never comes about without dysfunctional surgeons, so we would need then to go and look at those surgeons.

They have teams of investigators who respond to individual complaints, and some of those complaints involve very complex investigations into particular cases or a whole series of cases. The way they look at the competence of doctors in an overall sense requires experts to be brought in to be quite proactive about how they assess people’s practices. Once they have been alerted to it and are thinking that way, I would not have thought that this would require a lot more people. It requires a different approach by the people they have and very close co-operation with the Care Quality Commission, plus one other thing that I have suggested, which is that they need to use more perhaps than they do what I have described as peer-review techniques—in other words to use the expertise that exists in the professionals who wish to root out poor practice, to identify where the problems are. So bring in, as it were, professionals for particular purposes.

Q68 Chair: In your view of the world, just to be clear, if the CQC identifies the surgical department of a hospital as being a problem, then, without any individual doctor or nurse having their practice questioned, inspectors could arrive from the GMC to look at a department, for example.

Robert Francis: The way I came to this was that, when the Royal College of Surgeons examined the surgical division in Stafford in 2007, it came to the conclusion that it was dysfunctional. If you look at the report that they wrote, it reviewed a whole stream of cases of people treated by surgeons and made comments on those, in some of which they thought there was no cause for concern and in others they did. In their 2009 report there is a catalogue of cases of concern. The peer review was to look at a department but obviously the individuals in it. That was information that, in my world, would be disclosed to the Care Quality Commission. It should be disclosed to the General Medical Council, in my view, and should have been. That would lead quite quickly to a professional regulator being able to identify individuals who would need their attention.

Q69 Andrew George: On the point you were making earlier that your inquiry also observed some very good examples in other hospitals of care and the nursing care training of healthcare assistants—support workers—and the proper support of nurse preceptors, you gave an example from page 1515 onwards of St

Christopher’s Hospice, where clearly you were very impressed. They clearly provided a Rolls-Royce service in comparison with others. I have checked, and what you fail to mention is that they have a registered nurse-to-patient ratio of one to two or four. When you have a resource like that, would you not acknowledge that you have perhaps the luxury of time and resources to provide all of that training and support that staff clearly deserve if they are going to provide the kind of excellent service that St Christopher’s does?

Robert Francis: You may be right about that, but in addition to training their own staff, they were going out and training staff in nearby NHS hospitals. Presumably they were being paid for that. It may require some resource, but we are dealing with a situation that requires remedy. We cannot have, it seems to me—it is unacceptable that we have—people who have no training, particularly no training in intending to exploit the compassion and so on, and allow a situation where people are left in filthy beds because people are not caring; I am sorry.

Q70 Andrew George: Of course I agree, but in terms of the two issues that arise from that, one which is newly qualified nurses and the right kind of support, which St Christopher’s clearly provides, your recommendation is that nurse preceptors should have a minimum of three months of undertaking personal care so that they can develop those skills and that understanding. You do not go further and ensure that they are able to develop their nursing skills, because a post-qualified nurse is unable to administer IV, for example. In your 290-odd recommendations, that is the only issue that I can see that you recommend with regard to newly-qualified nurses. I wonder whether you felt that you could have gone a little further in terms of giving them support and opportunities.

Robert Francis: Can I remind you that my brief was not to review nursing or medical training as a whole but to learn the lessons from Stafford? I was seeking to address the appalling level of care delivered by some nurses in a particular field. You may be right; you may be wrong; but it is simply about the further training that is required. To my mind, I am still shocked that I have to say that there needs to be some standard requiring nurses to have that sort of hands-on experience. Of course many do, but it seems to me that it is not a standard requirement and I believe it should be. I rely heavily here—I make no secret of it—on my nursing assessor, who now has another job to do in relation to the aftermath of this, but we need to ensure that nurses not only do this work but that they have the aptitude to do it. The only way to test that is by getting them to do it, frankly. It sounds basic.

Q71 Andrew George: Further to the very welcome comments you made about health support workers, and following Dr Wollaston’s question in terms of the resource implications of your recommendation, did you see with the health support workers, because they are very low paid, that there was clearly, inevitably, a higher turnover of them and, therefore, if you are going to keep them in a particular job and invest

training time, there must be a resource implication going forward?

Robert Francis: It seems to me that either we value the work that these very important people do or we don't. They need recognition and support as much as any other worker in the hospital system. Making mend and do by hoping that the ward sister, or whoever it is, is keeping an eye on people is not a way to instil a coherent culture to which everyone in a hospital is signed up. I am not suggesting anything terribly elaborate or necessarily anything that lasts, but I think we need to have a conversation between those who know about these things about what is it that is required of people in this category and how we ensure that they are given the ability to do it.

One just has to think about how someone with no training, probably very few qualifications of any sort—not that you need academic qualifications for this sort of work—is plunged on day one into a ward full of elderly confused patients and given the equipment with which to wash and clean them, with the occasional passing comment of some nurses, which should not happen but it can happen. It is not surprising if things go wrong. So we need to put more in place here.

Q72 Rosie Cooper: You found a confrontational and defensive approach to handling complaints that were made to the Mid Staffs trust. Do you believe that the present complaints process requires further amendment in order to properly address patient concerns?

Robert Francis: The system is there in theory and it is probably more about how people work within it. What happened in Stafford was that lip service, it seems to me, was paid to the concept of complaints more than the practice. So complaints were received and there was a letter sent back, often not quite addressing all the points that were made by the complainant. In so far as the complaints were addressed, there was the action plan, which I have said more than once is a notable feature of the National Health Service, where everything gets an action plan, but the problem tends to be, "Does any action actually follow from it?" People were fobbed off, frankly, with a routine apology, a cursory examination of what the complaint was about and an action plan, which could not have been implemented because we then see six months later the same thing happening in the same ward and the same sort of letter coming out with the same sort of action plan.

The system is there, but it is about making it real. The way to do that is to spread information more widely about the complaints. First and obviously, trust boards need to be far more gripped than the Stafford board was with the reality of complaints. That means not just having the figures, but, as a lot of boards do now, seeing complainants.

Chief executives should take possession. This chief executive had letters put before him and he signed them, so he took ownership to that extent, but chief executives need occasionally to see complaints. Mr Sumara, in trying to sort all these things out, was seeing complainants on a daily basis almost, as far as I can see.

But, just as importantly, the substance of the complaints needs to be shared with the commissioners, the Care Quality Commission and—I see no reason why not in a suitably anonymised form—with the public. There would be visibility then as to what is happening about these things. If we are seeing a repeat of elderly patients breaking their legs because they have been falling over in a particular ward because no one was there to help them to the toilet, and that has happened two or three times, we will be beginning to wonder whether this is a hospital capable of maintaining fundamental standards and, therefore, whether the service of this particular ward, or whatever the service was, should be allowed to continue. That is a commissioner's job, it seems to me, as well as the regulator's job. Between them, you have two organisations, at least, and in the background the public through patient involvement groups or whatever, being able to bring pressure to bear to make sure these things are done. I am not sure that changing the structure is necessarily the answer. There may be tweaks that could be made to it. It is about ensuring that the structure we have is acted on properly.

Q73 Rosie Cooper: Absolutely, but I don't think Mid Staffs was short of any public information and anger. It was what was going on in the hospital.

Robert Francis: It was, if I may say so—this is not a criticism of anyone—the desperation later on that produced *Cure the NHS*. Before then, people's complaints were not being heard but there was not that public outcry.

Q74 Rosie Cooper: I suppose that is where I am going. Complaints are expected to be resolved locally, and they can range from the very simple—I suppose in the early days they would be—to the fiendishly complex and horrific, which is, I would suggest, where Mid Staffs ended up. For me, there has not been a support or advocacy agency as effective as the community health councils—now long gone. Everything I have come across since then have been pale shadows. So when local resolution fails, the complaint often ends up with the Ombudsman, who only investigates a tiny portion, a small percentage, of the cases. I was wondering whether the high probability that the Ombudsman is not going to investigate—nobody is really going to prosecute the patient case—is the reason that those who are guilty of poor practice bank on getting away with it.

Further to that, in your report, you considered the work of the Ombudsman and the complaints made about Mid Staffs, but you did not make any recommendations about the work of that office. Could you comment on that, and then what role does the Ombudsman have in the future? If so few complaints get there, it really perhaps is still a worrying situation.

Robert Francis: Yes. Partly in answer to this but also partly something I forgot to mention in relation to the last question, one of my other recommendations is that there should be a much more extensive use of independent investigation of complaints, leaving the responsibility for that in the hands of the trust because that is where they are responsible primarily for doing it. There is some use at the moment of arm's length

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investigation by some outsider being appointed to come in and do it, because, if you do that, you get a report from an outsider who sets out things, one would hope, in a systematic way, and you have a report that may well identify systemic issues where they arise. That can be shared with the commissioner, the regulator and so on.

You are quite right that I considered the work of the Ombudsman. I recognise that only a tiny proportion of the complaints that she receives are then taken up and investigated, and of course only a tiny proportion of those end up being upheld. Underlying all that, of course, is the other factor, which is that the Ombudsman only gets a tiny proportion of all the complaints that are made anyway.

I made no recommendation for this reason. It seemed to me that the Ombudsman performed a highly valuable function but at a high level. Because of the nature—almost random, if you like—of the cases that get to the Ombudsman, she is able to produce, in my view, highly valuable reports as to learning about handling of complaints and about particular interventions and so on, which are valuable. Who knows what the Ombudsman personally thinks, but I do not see the Ombudsman as ever being the solution to ensuring an effective complaints-handling system in any given hospital and guaranteeing that that is the position all over the country. The only way you are going to have that happen is by local intervention from the commissioner, the Care Quality Commission, the local inspector and local patient groups, whoever it may be—Healthwatch or whatever. So I would prefer to see a strengthening of the local surrounding of the trust by all those interested groups to keep an eye on complaints because they will have a better understanding of what is happening locally. That is why I made no recommendations about the Ombudsman. Does that answer your question?

Q75 Rosie Cooper: It does and I am sympathetic. The independent angle is the really good new element to it. I think most people still struggle to even get close to getting complaints resolved. In terms of accountability, everybody then just looks at the Care Quality Commission as the big back-stop and, if it gets through there, well, “It is your fault anyway.”

Robert Francis: Can I add two things? I am sorry if I keep on forgetting things I should be saying. You asked about support for patients making complaints. Two things struck me in relation to the advocacy support that was available. First, the support seemed to be largely focused, in an understandable way, on those who would be described as having difficulties—people with disabilities or whatever—and that is perfectly understandable. But less support was offered to people who were what one might just call ordinary patients, ordinary members of the public—the people that form the vast majority of those who complain—on the assumption, I think, that they can speak for themselves.

As you quite rightly say, people making complaints are in an extremely vulnerable position. They are dealing with a complex system. They don’t understand it and they need help. Not everyone wants it, but I don’t believe that sufficient help is available.

Part of that, which I found very striking, was the understanding at least of the advocacy support in Staffordshire—that they were there to help formulate a letter, for instance, or to accompany somebody to a meeting with the trust, but not to provide advice about the substance of the support. As a lawyer, I find that a rather difficult concept because, if I am an advocate, I am allowed also to give advice to someone about their complaint in the sense of, frankly, “Is this a good one or isn’t it?”, or, “Have you missed something out?” It is that sort of support you need, or, “Would you be better off getting a solicitor because you have a negligence case?” I do not know why an advocate should not be allowed to provide that sort of advice. I think the reluctance is partly to do with training, and you would need a little more knowledge, but there was too much of an inhibition there. That is what I would say about advocacy support.

Q76 Dr Wollaston: This question touches on complaints that are raised after patients leave hospital, but time and again we hear reports of patients lying in their hospital bed feeling frightened about raising complaints and that staff would be vindictive towards them. This is shocking. Do you have any thoughts about how we can make it easier for the patient—or their family—in the hospital bed to raise this and how can we change the system to make that more responsive?

Robert Francis: Some hospitals will send governors round talking to patients on a regular basis, and some are better than others at that function. People are possibly more willing to talk to an outsider. I think that there is a potential role—you might think not adequately discussed in the report—for helping those who cannot speak at all for themselves, who need some sort of voice when they are in hospital. But it is very difficult. You have the nurses there, you have the patient there, and unless you change the culture and root out that sort of behaviour—and that requires responsibility on the part of those running it—it is quite difficult to see the answer to that.

The one answer I will give is that PALS does not work in this context. It has its value, but its value is to do with facilitating communications, perhaps, and advice of that nature, rather than anything else. It is too intrinsic to the trust itself to be of help. You need more transparency. Part of what I have said is about being more welcoming to families and their involvement in what is going on, and the more people you have—the force of numbers—occasionally overcomes the vindictive nurse, one would hope. In so far as they exist—and we know they exist; they did at Stafford—it is, I am afraid, the duty of those around them to root that out. I cannot see any other answer to that.

Q77 Dr Wollaston: It is not just vulnerable people who find it difficult to raise concerns. Even quite powerful individuals feel totally powerless in a hospital setting. We heard a case recently of somebody having to phone the police to get somebody to give them some water on a ward. Do you think there should be another mechanism within hospitals for people in that situation to be able to raise concerns?

Robert Francis: One of the things I have said in the report is that there should be multiple gateways through which to make the complaint, even if it ends up back in the trust. I have suggested, in more general terms, that commissioners need to have a higher profile so that people understand who they are and that they are somewhere that could be approached for that. One other thing, which does not quite relate perhaps to the question but is in the broader context in terms of deterring behaviour, is that the part of my recommendation about fundamental standards and how they are regulated would require the Care Quality Commission to pay attention more to individual cases than it has done hitherto. You will have seen my identification of a regulatory gap between the Health Safety Executive and the Care Quality Commission. If the offence is serious harm to a patient for breach of a fundamental standard, it involves looking at an individual case and that may bring them in more. What we are getting to is that another source would be to complain to the CQC.

You need to get a complaint outside the hospital, but people are going to be afraid because they are still in hospital and that nurse is still there. The only reality I can see is that that has to be dealt with within the hospital.

Q78 Chair: It is quite striking that several times in the last two and a half hours you have referred to the role of the commissioners. They should have an important role in identifying failure of the kind that we saw at Mid Staffs, but in your report you say, “Throughout the period under review, the purchaser/commissioning arm of the system was subjected to constant reorganisation, usually taking place well before it had been possible to put fully into practice and embed the aspirations of the previous changes.” In other words, this was there in theory but constantly changing in practice and virtually powerless.

Robert Francis: Yes.

Chair: Is that a fair conclusion to draw?

Robert Francis: Yes.

Q79 Chair: It is not a problem that has gone away, I suspect.

Robert Francis: I believe that, when reforms of this nature are made, they are made usually, one would hope, for good reason. But it seems to me you have to follow through the logic of what it is saying. If you have commissioning, whether it is by a primary care trust, a GP commissioning group or the Secretary of State—

Q80 Chair: They were called “health authorities” when they were first introduced, and it is 25 years ago now.

Robert Francis: I remember them. You need to equip them to undertake the job properly. Commissioning of a contract for building a very complicated building involves quantity surveyors, who go and look to see if the work has actually been done, and there are penalties involved if it is not done. If you do it for a complicated building site, I do not see why you cannot do it for a complicated service to human beings and ensure that the same thing has happened. I believe

commissioners should have that responsibility. It was not really understood like that, it seems to me, under the primary care trust regime. Their job was much more limited and it was part of the reliance on other people having the responsibility when it came to looking at quality and safety matters. That has to change, and I believe that there is the capacity in the theory of commissioning under the present arrangements for that to happen, but it does need resourcing and it does need support.

Q81 Valerie Vaz: Can I go back to the complaints part? I don’t know if you had a chance to read our report in 2011.

Robert Francis: I quoted it in mine.

Valerie Vaz: It is good that you did that, but I don’t think the Government or the CQC have even looked at it. In recommendation 1 you have said that we are quite an important body to look at things. I suppose we are, to a certain extent, because the chair and the chief executive of the CQC both resigned before they were due to come and appear here, so we do have the fear factor as well.

I am very interested—partly as a lawyer—in complaints and litigation, and I don’t know if you are aware that the litigation bill is now reaching £1 billion. I am wondering whether this local resolution is a matter of resources. If there is no legal aid for initial advice, they cannot do what you suggest—to decide which are the good claims, which are the bad claims, and which ones to take forward. We have heard evidence of people being in the system with their complaints for seven years sometimes.

You mentioned local resolution, and I agree with you that PALS has its place but does not help when the patient on the ward wants that blanket or drink of water. I am wondering if the legal system can play a part, maybe with different pre-action protocols or more resources at legal aid level, at local level, where people can see the difference between a concern, a proper complaint and proper negligence.

Robert Francis: All I can properly say, on the basis of this report, as opposed to putting some other hat on as a former chairman of the Professional Negligence Bar Association—which is not why I am here—is that there is no doubt that, looking at the experience of at least one family that I have mentioned already today in another context, the litigation system is profoundly unsatisfactory. This case was where a son died and they got an inquest where, as far as they were concerned, the full story was not told. They were not told the full story, and a settlement of what seems to most of us quite a small sum of money was provided. They received a letter of apology. They then see in the press, of course, that the letter of apology was in one sense offensive; they see in the press that, contrary to their current understanding, the trust is saying, “Well, we have settled this very generously, but there were of course points we could have taken in defence of this claim.” So they were not even accepting liability, despite their own consultant telling them it was indefensible. There is something hugely unsatisfactory about that as a process and the more that can be done to ensure early settlement the better.

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I hope that my recommendations about the duty of candour will be brought into effect. I appreciate that one reason that there is reluctance relates to what effect that has in relation to potential compensation claims, and I have some quite robust things to say about that, if you want me to. One is that if wrong has been done to a patient—if a public service has actually harmed somebody and injured them—then they deserve compensation. They deserve first to be told that that has happened and they deserve for that wrong to be put right. There are all sorts of ways in which that might be done. An apology might be enough, a promise that “We will put things right” might be enough, and compensation might be necessary or it might not be. But we have to be honest about that. If we are not honest about it, the litigation bill will get bigger and bigger, because people will go on these days until they receive justice and satisfaction, and many would say, “Quite rightly so.” If you want to put me and my colleagues out of business, settle all these things at the earliest possible time.

Just as importantly, if the health service is to learn lessons from mistakes that are made, they need to put them right at the earliest possible stage. It is no use trying to draw lessons from an obstetric disaster eight years down the line after it has been settled for millions of pounds in court. That is no system. I have not emphasised much about litigation in my report because it is not a solution, I am afraid, to very much.

Q82 Rosie Cooper: Might I, very finally, wrap up part of my thinking about complaints? While we have been discussing complaints, the CQC has been mentioned a number of times as the regulator. There is a difficulty in that the CQC does not investigate complaints, and it is very clear that it does not. If something is referred to it, it will inspect and perhaps have a particular eye to the nature of that, but it will not go back and indicate to the complainant that it has investigated that area. It will formally appear in a later report. I have suggested that that be sent to everybody. But the CQC does not investigate, and that often leaves people feeling that, locally, it has not been resolved; the CQC has been there and it will not investigate that particular complaint.

Do you think there is a problem with people understanding the nature of it, each time we say “CQC’s involvement”, that they actually understand what it is prepared to do and its level of involvement? I know you have suggested that MPs look at trends. I do that and I get shouted at by my local hospital for just that. It is really important, but everyone is confused. In the end, I referred my hospital to the CQC because I just wanted it stopped and sorted out. But I think there is a real problem in understanding there.

Robert Francis: I understand that entirely. My recommendations would lead to it, at least in serious cases—that is, where death or serious harm is caused by a breach of the standards—as it is the prosecuting authority under that theoretical notion, having to investigate individual cases. The challenge, obviously, is that, if the Care Quality Commission was asked to investigate or have some role in all complaints, we

would be back to where the Healthcare Commission was when it had imposed unwillingly on it the second-tier system of complaints, which everyone agrees, including them, did not work.

The only way complaints can be sorted out is at local level, in general terms, but there is a role for something else in very serious cases. Other than that, I would have thought it has to be a local resolution. There does need to be clarity of responsibilities so that the public understand where they go to for different things. That is certainly lacking at the moment. Because the system is so complicated, I have spent three years now looking at more organisations than I would care to which are involved in decisions—and I am sure you have—and it is still sometimes difficult to get my head round who it is who does what.

Q83 Barbara Keeley: On NHS leadership, the question is what are the other lessons about leadership for NHS directors and managers? You have talked about the disempowerment of clinicians in favour of managers, the impact that had and the need for managers to be trained in ethics to enable them to act based on core values. Just now you talked about complaint structures and trust boards and chief executives being aware of those and being more visible in that process. But are there other lessons about leadership that you want to touch on that you have not already covered today?

Robert Francis: I did talk about leaders exemplifying the reality of the culture. Trusts take their culture, I think, largely from chief executives, or the leaders in that sense, and should do so when it is a good leader. We are never going to get that if leaders of trusts stay in office for, on average, less than or around two years. There may be something to be said for them not staying, generally speaking, for decades, although some very successful ones do, but there is no stability here.

It is the most challenging job I can imagine, running a complex organisation with huge numbers of activities, large sums of money involved and pressure from all directions, and we do undervalue, I think, the skills required to undertake that role. So I emphasise the need for training for it—not specific qualifications because there is value in leaders coming from all over the place, as it were. We need to encourage the more clinically qualified, people from healthcare professions, to get involved in this, and that is one reason—but only one reason—for spreading some form of regulation to managers in general so that they are all on a level playing field. At the moment, I believe there is a bit of a deterrent involved in asking clinical leaders to step up to the plate so far as management is concerned, because in the boardroom they are the ones who can get called up in front of their own regulator. The guy on the other side of the table who happens to be the chief executive is not. There is no reason why there should be the sort of limit there seems to be on the number of doctors or nurses you can have on a board, and there should be more people encouraged to take on the role of non-executive director, for instance. They bring huge experience and should be encouraged to do so.

So we need a more ethical background, people who are role models to be executives and leaders, and we need much more clinical engagement in these posts. If you put all that together, it may be—I would hope—that you get the culture that we need, putting the patient first.

Q84 Barbara Keeley: I have a final point about culture. There was this culture of promoting positive information while discounting other less favourable news, and that is a key thing. If it is possible to summarise, what would you say was the remedy for that?

Robert Francis: The discounting?

Barbara Keeley: Yes.

Robert Francis: It comes in various forms. The striking one is taking comfort from—and I am making up the figures—a staff survey that says “60% of your staff would recommend their relatives to go there” as being an improvement on the 55% it was last year. As I said before, if you are leading a trust, what you need to be interested in is the 20% or the 10% who say things are going wrong, burrow down into that and find out what is going wrong, talk about it to people and be open about that. Your aspiration on most of these tests should be 100% positive, not less than that. So that is the first point.

The second point is to require balance in the information that is put out. That can be done prescriptively. I think there is a development happening in relation to that in terms of quality accounts, which are a vehicle through which we can require these organisations to be honest about what is actually happening rather than burying—if they put it in at all—the bad news in appendix 5 alongside the pension details of the directors, figuratively.

Chair: Several colleagues have promised a final question. I don’t know whether anyone else has one.

Robert Francis: Barristers do it all the time.

Chair: I know Sarah has one she wants to ask as a final question.

Q85 Dr Wollaston: You made 290 recommendations. I am keen to give you an opportunity to reiterate to the Government what they should prioritise. What is going to give us the greatest effect? What should they focus on?

Robert Francis: I have made 290 recommendations because they come as a package. Within that package

various things require development, but I am not going to say that one is more important than the other. What are important are the principles underlying those and the five areas that are contained within that.

The first is about producing fundamental standards for which there is zero tolerance of non-compliance, backed up by rigorous actions.

The second area is that we must promote openness, transparency and candour. That is a package. It is about candour to patients, but it is also about honesty with the public, commissioners and regulators.

We need to strengthen nursing. It is absolutely vital to strengthen nursing and the values that that can bring. I have recommendations about that.

We need to strengthen leadership, and I have said something about that.

Finally, something about which perhaps we have said less today but which is as important as the rest—if not more important—is making more usable, comparable practical information available as quickly as possible about the performance of organisations so that, whether it is commissioners, members of the public or parliamentarians, dare I say it, we can all make an assessment and a judgment about the service that is being provided. As I say, my ideal would be to be able to click on a website and find out what the infection rates are in ward 11, or, if I am going in for heart surgery, I can burrow down, as I am beginning to be able to, into a website and find out what the mortality rate is for the surgeon or—more realistically in the NHS—the surgical team I am going to. I should be entitled to know that. We need information that provides that in real time, but, picking up one of the questions, that does require significant advances in information technology to be available within the system.

I am sorry I have not completely answered your question, but my recommendations come as a package, and there are as many as that because I have tried to combine directions of travel in some of them with some more practical recommendations. If you break it down, I must have looked at about 20 different types of organisation and activity. So, if you spread those recommendations out among them all, it is not very many.

Chair: With that consoling thought, we say thank you very much for coming this morning. We shall certainly be following it up. Thank you very much.

Tuesday 5 March 2013

Members present:

Mr Stephen Dorrell (Chair)

Andrew George
Barbara Keeley
Mr Virendra Sharma

David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: **Sir David Nicholson KCB CBE**, Chief Executive, English National Health Service, **Professor Sir Bruce Keogh KBE**, NHS Medical Director, and **Liz Redfern CBE**, Director of Nursing, NHS South of England, gave evidence.

Q86 Chair: Good morning and welcome to the Committee. The first thing I have to do this morning is to present apologies on behalf of four of our colleagues on the Committee who have been detained elsewhere and have asked that their apologies be presented. Chris Skidmore, Grahame Morris, Rosie Cooper and Andrew Percy are all unable to be with us. We are grateful to you for joining us this morning. I would like to say a word about the background and the purpose of this morning's session before we start. The background is, sadly, very familiar to all of us—a scandalous failure of care in an NHS foundation trust that was supposed to serve the people of Mid Staffordshire. I think we all agree that it is deeply shaming for the national health service as an institution that these events should have happened. It is shaming for the NHS as an institution and also for those individuals who are implicated in that failure of care—so shaming, in fact, that it prompted an apology by the Prime Minister to the House of Commons following the publication of the second Francis report. That is the background.

The purpose this morning is to hear from our witnesses how these circumstances came to be and what now needs to change as a matter of urgency within the health service to ensure that nobody needs to sit on an equivalent Committee one, two, three or five years hence, answering questions about similar circumstances having arisen again.

The report by Robert Francis attempts to address those questions. He builds his 290 recommendations around a core requirement for a change of culture in the way care is delivered in the health service. I would like to open the questioning by asking our witnesses what they understand by this phrase “change of culture”. What does it mean, and, perhaps even more importantly, how is it going to be brought about?

Sir David Nicholson: Thank you. One of the things that Francis says in his report and has said subsequently is that everybody who was involved—everybody who was in the NHS at the time—needs to reflect on the report and the sorts of things that you described, and work out for themselves what they need to do, both in terms of changing the way they are and what they need to do going forward. That is a really important bit of thinking about culture.

If I reflect back on the report—and I have to say that I reflect back on both reports because there was, obviously, the first one that particularly dealt with the hospital. I remember the time that I sat down and went

through those patient stories. There is a great big pile of patient stories that were published at the time, and I spent the whole weekend going through them. Like anybody, any human being—particularly someone who has spent almost all their professional life in the NHS trying to improve services for patients—it was a deeply, deeply saddening process. Out of that, I wrote to all the chairs and chief executives saying that every board should read those patient stories. They were not statistics or targets; they were patient stories. In terms of understanding the way a culture operates, understanding those stories is really important.

All I could do in those circumstances, as you know, was to apologise to those people, because not only did they get really poor, appalling care, but also, when they faced the NHS with these issues, the NHS denied it had happened, which was absolutely appalling. In response to that, I decided to redouble my efforts to improve quality and services in the NHS, and that is what, hopefully, people will say I have been doing over the last few years.

When I particularly reflect on the culture at that time in 2005–2006, I was responsible, as members know, for 10 months for one particular strategic health authority; there were three that I was responsible for. Essentially, the Government had announced their abolition or merger together, so I was running them down. The NHS at that time was neither equipped nor capable of monitoring the quality of those organisations. Not only that, but the strategic health authority that I was responsible for neither had the capability nor the capacity to do it. On top of that, there was no sharing of information across the system as a whole, whether it was regulators or whatever.

In a sense, that analysis led me to apply for the job of chief executive of the NHS. This is not something I am saying now; I actually said it at the time—that I felt at that particular moment that the leadership of the NHS had lost focus on what was really important for patients, which was patient safety and the improvement of services. So that is what I started to do right from the beginning as chief executive of the NHS, whether it was focusing attention on improving services for stroke, coronary heart disease or cancer patients, or attacking infection in our hospitals, or whether it was making sure that when patients were diagnosed they were treated as fast as possible.

At the moment—and this is why the culture point is so important—the NHS is facing its greatest challenge. In the next few days, we will abolish over

160 organisations and set up another 211 local organisations and a whole myriad of national ones. We will completely change the way in which we allocate resources and incentivise the NHS. At the same time, we are losing—well, we have already lost—13,500 administrative and management staff, who have all that corporate memory in them. It is at maximum risk over the next few days.

I said two years ago that I would take the responsibility of leading the NHS through this enormously complex set of changes. I promised both the Government and the NHS that I would see that through. I am absolutely determined to do that over the next period.

On top of that, of course, the Francis review gives us a huge opportunity to accelerate some of the changes that certainly I have been advocating for some time, but which Francis sets out really well in his document, around getting patients at the centre, zero tolerance of patient safety incidents, tackling a whole series of issues with the way hospitals are run, and transparency. We have a real opportunity to do all of those things over the next period, and I am really looking forward to making that happen.

Q87 Chair: Can I bring you back to this concept of culture change and my question about what is at the heart of the change of culture required? If you had to put three bullet points on a sheet of paper as a circular round to the NHS, what are you looking for, and how, when you go to a trust in April or May 2013, are you going to make yourself confident that they get it—that they understand the need for change?

Sir David Nicholson: The first thing—you can see it absolutely played out in Mid Staffordshire and in parts of the NHS where there is poor care—is that motivated, supported staff provide great outcomes for patients. That connection seems to have been lost in a whole set of discussions about systems and processes. It is that basic fundamental thing. What you do when you go to a hospital is you talk to the staff, look at their results, see what they are doing, and you make an assessment as to whether they are supported and whether they feel that they can provide the best care for their patients. That gives you a really good opportunity to judge whether outcomes are better.

The second thing is that one of the things that came out of the report “High quality care for all” was that what really high-performing clinical teams do is measure things. It is the distinctive characteristic. As well as having the compassion, they measure things. If I think about 2005, there were probably 20 or 30 indicators around that you could measure. As we sit here today, we publish for most hospitals—in fact, all hospitals—over 600 various measures, such as stroke audits and all of that. So it is measuring things. What they do is they measure things, set themselves goals and deliver improvement for patients. Then they benchmark themselves against other clinical teams. That is the way they drive improvement. So you would look in a hospital at the way in which improvement for patients is driven.

The third thing is this thing about patient focus, and it is very interesting. One of the things I often see when I go round to hospitals is that most of them have

in their strap-line or mission, “We love patients,” or “The patients are at the centre of all we do,” and all the rest of it, but they sometimes find it quite difficult to explain how they put that into action. But that is a really important question. They are the three things I would say about hospitals.

Q88 Chair: I will have one more shot and then I will pass it to Valerie. Two linked words that I was listening for in what you said, which I think reinforce what you have described as your three bullet points but which you did not use, are “accountability” and “openness”. Both words feature strongly in the Francis report. Do you not think that needs to be an important part of what we understand by “culture change”?

Sir David Nicholson: Absolutely. I did not mention those words particularly, but, if you think about what I was saying there, particularly this issue about measurement and transparency in what we do—I am sure we will get on to hospital standardised mortality and all that sort of thing at some stage during the conversation—that kind of data is really important to get out among the population so that we can have really transparent discussions about it. It is the thing that will drive change in the system—clear accountability; accountability at every level, from the accountability of individual professionals to their patients, through to the accountability of the chief executive of the commissioning board and the Secretary of State.

Q89 Valerie Vaz: Good morning, Sir David. Please do not feel that this is a trial; this is trying to elicit some information, as not all of us could be at the Francis inquiry. I have before me your statement, and I hope one of your officials is going to give you a copy of the statement because I do want to refer to it. Earlier you said you sat down and read patient stories. When did you do that?

Sir David Nicholson: That was when the first Francis report was published; so that would have been 2009. He published both the report and an annex with all of the patient stories in it.

Q90 Valerie Vaz: You did not do that at the time when you were at the SHA.

Sir David Nicholson: No.

Q91 Valerie Vaz: I suppose that is what struck me about your statement. It is very much like you are a process man and a procedure man, and I could not find anything—and please help me if I have made a mistake—about patients in there, what you are going to do and quality of care. Is that fair?

Sir David Nicholson: It is certainly unfair to say that I am a process man. Anyone who works with me or understands the way I work knows that I am absolutely focused on improving services for patients. Certainly in my substantive job, which was as the chief executive of Birmingham and the Black Country, there are lots of examples of how I drove patient improvement there, particularly around people with long-term conditions and hospital services. So there is a good record.

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The issue for me is that during that period, across the NHS as a whole—not just in that part of it—patients were not the centre of the way the system operated, for a whole variety of reasons. It was not because people were bad or anything like that, but because there was a whole set of changes going on, a whole set of things that we were being held to account for from the centre, which created an environment where the leadership of the NHS lost its focus. I will put my hands up to that and I was part of that, but, in a sense, my learning through all of that is never to let it happen again.

Q92 Valerie Vaz: I also could not find an apology in there.

Sir David Nicholson: I am sorry, but I did apologise at the time. I subsequently apologised.

Q93 Valerie Vaz: Yes, but not in the statement.

Sir David Nicholson: Is there not one in the statement?

Q94 Valerie Vaz: I am asking you. It is your statement.

Sir David Nicholson: I am absolutely sure there is an apology somewhere in there.

Valerie Vaz: Good. Maybe you can find it later.

Sir David Nicholson: I am absolutely confident there is.

Q95 Chair: Can I turn to page 22, paragraph 75? Right in the last sentence you said: “I had oversight of the day to day operation of the three SHAs whilst also designing the future.” So you were the one in control. Is that right?

Sir David Nicholson: Where is this?

Valerie Vaz: It is the last sentence.

Sir David Nicholson: Okay, yes.

Q96 Valerie Vaz: You are the one in control. You are responsible for all the SHAs there.

Sir David Nicholson: I was responsible for the three SHAs at the time.

Q97 Valerie Vaz: That is what you said there—okay. Now, in paragraph 79, page 23, in the middle, you say: “My feeling was that people were not being properly held to account, for example, action plans were being agreed but not delivered. There were also a number of issues in the area that needed sorting out.” What did do you about it?

Sir David Nicholson: I sorted them out.

Q98 Valerie Vaz: What did you do?

Sir David Nicholson: If you think about that time, I was—

Q99 Valerie Vaz: No, no; I was not there. I am asking you because you said there were some issues and things were not being delivered. So what did you do about it, having said that you had oversight of all the SHAs?

Sir David Nicholson: I appointed a managing director for each of the strategic health authorities. As you can imagine, given that I was running three and at the time

I was responsible for the national work on HR, the amount of time I could spend in each individual one was relatively limited, so I put people in to deal with that.

The issues that we were tackling were that many of the organisations were having difficulties delivering what you might describe as the basics for the service, as defined at that time. I have to say the definition at that time was essentially that access was the way in which quality was defined. So their ability to deliver their A and E targets and access waiting times for patients and to reduce healthcare-associated infections were the things that the whole of the NHS and those SHAs were held to account for and were effectively working on at the time.

Q100 Valerie Vaz: That was to you. They were obviously held to account to you.

Sir David Nicholson: Yes, and I was held to account nationally for those things.

Q101 Valerie Vaz: Yes. On page 25, in paragraph 84 you talk about talking to the three chairs. What did you talk about?

Sir David Nicholson: Sorry, I will just find—

Valerie Vaz: Do you see your quote: “I will continue to take oversight of the process for establishing the proposed new SHA and will continue in my role as Chief Executive, with the three Chairs to take overall responsibility for the management of the three SHAs...I will meet with them on a fortnightly basis”. At that stage, when you were talking to these three chairs, did you find any rumblings about what was going on at Stafford hospital?

Sir David Nicholson: No. There were absolutely no rumblings. The local chair and the three boards continued to operate during that period. The local chair raised no issues. I am sure in his statement to the inquiry that he said he had no idea that the kind of appalling care that was going on at Mid Staffordshire was actually going on.

Q102 Valerie Vaz: So people are running an organisation and do not know what is going on. That is effectively what you are saying.

Sir David Nicholson: The SHA was not operationally responsible for the trust. There is an issue about accountability here that I want to explain. Part of the issue here is that people see the NHS as an organisation, when it actually is not. It is a healthcare system. It is a whole set of statutory bodies with their own legal responsibilities. Mid Staffordshire NHS trust was a statutory body with its own accountable officer, accountable to Parliament. The system is built up to make that accountability run at hospital level.

As you can read, both the Francis reports say that the primary accountability for what went wrong at Mid Staffordshire hospital was that particular hospital, and those individuals were held to account. As you know, the chair, the non-executive directors, the chief executive, the finance director, the corporate affairs director and the medical director all went. The nurse director was moved. So it is not true to say that people were not held to account in the NHS. They were and they went.

My accountability was very different from that in the sense that I was held to account for delivering the change: for delivering three SHAs into one; for moving I think it was probably 70 PCTs into about 40, or 32—I cannot remember the exact number—at that date; for making sure that all the organisations delivered what was regarded as the “must-be-dones”, which is essentially access and MRSA and C. diff. reduction. That was narrow. I accept that that was a narrow definition of accountability, but that was the way in which it worked. I think it shows in the Mid Staffordshire Francis report that that was a big failing in the whole system.

Q103 Valerie Vaz: And you were in the middle of it.
Sir David Nicholson: I was in that system—

Q104 Valerie Vaz: You were in the middle of it.
Sir David Nicholson:—and I was part of it, absolutely.

Q105 Valerie Vaz: Turn to paragraph 87, page 27, where it says that counsel to the inquiry said that Cure the NHS said it was chaotic. Cure the NHS described it as “chaos” in the west midlands, and you have refuted that. What would you call it then? You have just described something to me that sounds very chaotic.

Sir David Nicholson: No; I did not say it was chaotic.

Q106 Valerie Vaz: What would you call it then?
Sir David Nicholson: I think the system in the west midlands as a whole—

Q107 Valerie Vaz: No. What would you call it, Sir David? If it is not chaotic, what would you call it? What name would you give to this process that is happening that you are in the centre of?

Sir David Nicholson: We were taking through a set of changes that were very difficult, that involved losing members of staff, changing organisations, losing corporate memory, all of those things, but it was done in an organised and planned way. It was not haphazard and it was not chaotic. It was actually planned and organised.

Q108 Valerie Vaz: The core function of the NHS is to make people well. You did not know anything about that. None of these concerns that happened at Stafford hospital came through to you while you were undergoing this process.

Sir David Nicholson: None of the—we had no—I had no idea. The information was not brought to the SHA. We did not see any of the information that would lead you to believe that there was all of this going on in Mid Staffordshire. As shocking as it is, that is the truth. It is not to say there was not information around in the healthcare system before I got there—and by other organisations—but we did not in the NHS at that stage. Shropshire and Staffordshire were no different, I guess, from most other places, where there was no culture of sharing information across the system.

Q109 Valerie Vaz: We are just talking about your particular area, aren't we?

Sir David Nicholson: Yes.

Q110 Valerie Vaz: Did you ever get information about mortality rates?

Sir David Nicholson: No.

Q111 Valerie Vaz: Never in all your time.

Sir David Nicholson: No.

Q112 Valerie Vaz: When did you first become aware of mortality rates generally?

Sir David Nicholson: When I was appointed as chief executive of the NHS, Dr Foster published a whole set of them, which I guess would have been in 2000 and—

Q113 Valerie Vaz: And you never knew in all your time in the NHS—from trainee—about people dying at all, at any level.

Sir David Nicholson: Of course, I—

Q114 Valerie Vaz: “Of course” in what way?

Sir David Nicholson: Sorry, I thought you were referring to hospital standardised mortality rates. I thought that is what you were referring to.

Q115 Valerie Vaz: Both.

Sir David Nicholson: I had not come across hospital standardised mortality rates during my period in Shropshire and Staffordshire, nor before that. It was only after that, and at that stage they were very controversial measures, I have to say. Part of the problem was that people got obsessed with the measure rather than what was underneath it. But, no, I did not have access to that information when I was at Shropshire and Staffordshire.

Q116 Valerie Vaz: Isn't that unusual?

Sir David Nicholson: No.

Q117 Valerie Vaz: You don't know anything that is going on in a hospital and you are supposed to be—

Sir David Nicholson: I didn't say—

Q118 Valerie Vaz: You didn't say that, okay.

Sir David Nicholson:—that I didn't know anything that was going on in the hospital. If you look at the information that we routinely collected, it would not give you the information that would alert you to what happened at Mid Staffordshire.

Q119 Valerie Vaz: So you didn't know that people were dying and you didn't know about complaints; you didn't know about these patient letters at all. You were just doing the process, but you were in the middle of it.

Sir David Nicholson: I have spent 20 years of my life running hospitals. I know exactly how hospitals run.

Valerie Vaz: We know.

Sir David Nicholson: I have done it myself. Of course I know that patients die in hospital, under good circumstances sometimes when end of life is managed really well, but under tragic circumstances in others. Avoidable deaths are things that all of us in the NHS have been more and more alerted to over the last few

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years, but at that moment in time, as surprising as it may seem in retrospect, it was not part of the regular way in which NHS organisations were monitored in the NHS.

Q120 Valerie Vaz: Let us turn to page 35, paragraph 110. You say: “On 27 October, I therefore went to Mid Staffordshire and visited both hospital sites, at Stafford and Cannock Chase. I believe that Martin Yeates, the Chief Executive, would have shown me around the hospitals, and we would have spoken to a few members of staff.”

Sir David Nicholson: Yes.

Q121 Valerie Vaz: You “would have”. You don’t know; you don’t recall.

Sir David Nicholson: I certainly went round the hospital. I go round—

Q122 Valerie Vaz: You did go round the hospital.

Sir David Nicholson: Yes, of course I did.

Q123 Valerie Vaz: Right, okay. So the “I believe” and “would have” are not correct. You did go round the hospital.

Sir David Nicholson: I did go round the hospital. One of the things about the way I work is that I do go round lots and lots of hospitals all the time. A lot of my working life is around meeting healthcare people and doing that.

Q124 Valerie Vaz: I understand that. We are talking about a specific time, 27 October 2005, so you did go round the hospital. Who did you speak to? You say: “...we would have spoken to a few members of staff”?

Sir David Nicholson: The point I am trying to make is that, given that I go round a lot of hospitals, I cannot recall exactly who I spoke to, in what order, in those circumstances.

Q125 Valerie Vaz: You must have had a diary or something, or some notes, because you would not have made a statement like this otherwise. I am pinpointing this key moment in time where you have already given evidence. I am not asking for anything different. I am just asking because you claim here that you were not sure whether you did go round the hospital or not, but you have. We have established that you have.

Sir David Nicholson: It is in my diary that I went round.

Q126 Valerie Vaz: So I am asking who did you speak to—“...spoken to a few members of staff”?

Sir David Nicholson: I always speak to staff. I always go round and speak to staff. I always speak to—

Q127 Valerie Vaz: Okay, I understand that, but we are trying to move forward, aren’t we? So I am trying to find out. You were there in the middle of Stafford hospital, where things are going wrong and you do not understand it. We are trying to find out how to make it better for the future. If it means you come out of your office at Richmond House and go down and

visit a few hospitals or feed a few patients, maybe that is what you should be doing. Do you understand my drift?

Sir David Nicholson: Absolutely; I understand what you are trying—

Q128 Valerie Vaz: So you are a process man.

Sir David Nicholson: No, I am not a process man. I went round those hospitals in Staffordshire. I was responsible for 50-odd hospitals across that place. I probably visited all of them while I was there.

Q129 Valerie Vaz: “Probably”.

Sir David Nicholson: I cannot go back through them. I would have visited all of the hospitals. When I go round hospitals, what I try and do is first of all make sure that I speak to patients. I would have spoken to patients. I cannot remember the particular patients I spoke to on that particular day, but I did. I would have spoken to members of staff. I always make a point of talking to the staff away from the managers. The question that I always ask them is something like, “When you are huddled together for warmth on a cold day having a grumble, what are the things that really worry you about this place?”

Q130 Valerie Vaz: Did you? Yes?

Sir David Nicholson: I always do that. If I see things that are wrong, I put them right.

Q131 Valerie Vaz: Good; thank you. Can we turn to paragraph 112 then? You said: “The two main concerns that were discussed during the meeting were the lack of senior individuals within the Trust to help the Chief Executive make things happen, and the poor relationship between the Board and the clinical staff.” What did you do?

Sir David Nicholson: Which number is this, sorry?

Valerie Vaz: Paragraph 112, page 36. Why didn’t you do something about it?

Sir David Nicholson: To help you with all of this, I spent 11 hours—

Valerie Vaz: It is me and the public—not just me.

Sir David Nicholson:—being cross-questioned by a QC in public. There are 500 pages of transcript. All of this information and more detail is available if you want it. What number is it—112?

Q132 Valerie Vaz: It is page 36, paragraph 112. What did you do and why didn’t you do something about it?

Sir David Nicholson: Okay. Martin Yeates and the chairman of the trust, Toni Brisby, had been brought in to the trust sometime before I got there to improve things in the trust. That is what they had planned to do.

What was clear was that Martin Yeates had been appointed on a temporary basis. The chairman was very keen to get him appointed permanently in that post because he needed a director of operations, a medical director and a nurse director, and he could not recruit them because why would people come and work for a temporary person? So we put plans in place at that stage both to bring the appointment of the chief executive to a head, but also then to make

arrangements to appoint a director of operations, a medical director and a new nurse director. So we helped him and supported the organisation making those things happen. That is what we did.

Can I just say that there is an apology, and it is on page 3. I am sorry but I just could not find that earlier.

Q133 Valerie Vaz: That is okay; no, don't worry. Let us go to page 37. It is a funny old trick; it is something that people do when they go on the witness stand. It's, "I can't remember"; "I can't remember." You seem to not be able to remember lots of things that go on. There it is at paragraph 116: "I cannot recall what we specifically discussed with regards to any recovery plan."

Sir David Nicholson: It is not a trick.

Valerie Vaz: No, no.

Sir David Nicholson: I was responsible for 53 organisations. With regard to two thirds of them, I had literally never been involved in them before in my life. They were brand new to me. I was going through this for the very first time. The idea that I could recall in detail every single one of the meetings that I had during that period is quite difficult in those circumstances. It is not a trick.

Q134 Valerie Vaz: No, and this is what we are trying to find out. Is it appropriate for you, as head of the NHS Commissioning Board, to have all this power? That is the problem. This is what we are trying to find out for the future. You had all this power and you could not visit every hospital, which seems to me to be the basis of accountability for people who pay taxpayers' money and expect a good service. Let me take you to—

Sir David Nicholson: Sorry, but can I just say something on that? I go to hospitals all over the country. I have been in this post now for nearly—

Q135 Valerie Vaz: But you can't remember which ones you go to. I suggest you keep a record.

Sir David Nicholson:—seven years. I do keep a record but I have not got—

Q136 Valerie Vaz: Good, but you didn't in this case.

Sir David Nicholson: I do keep a record, and I can remember going to Mid Staffordshire, to Stafford general hospital, and I can remember going to Cannock Chase hospital. I can't connect—

Q137 Valerie Vaz: Once. You remembered it once, didn't you?

Sir David Nicholson: I have been to Stafford general hospital on a number of occasions.

Q138 Valerie Vaz: Did you? At paragraph 118 you say, "Aside from my meeting at Stafford Hospital on 27 October 2005, I cannot recall visiting the hospital on any other occasion during this period, or recall any issues being raised in relation to the hospital."

Sir David Nicholson: I am sorry; I am obviously getting it wrong here. You asked me about my role as chief executive of the NHS, and I have visited Stafford general hospital a number of times since I have been the chief executive of the NHS.

Q139 Valerie Vaz: Since, yes. I am talking about what happened here.

Sir David Nicholson: I am sorry. That was a complete misunderstanding. I understand what you are saying.

Q140 Valerie Vaz: So you only visited it once, even though there were concerns about it.

Sir David Nicholson: There isn't a hospital—in all of the hospitals that I was responsible for there were things that needed to be done, so it was not—

Q141 Valerie Vaz: You were adamant previously that you do not recall being shown round—"I would have been shown round"—but here you are adamant you never visited it again. Is that right?

Sir David Nicholson: There was no record of me visiting it again in my diary and I cannot remember having visited it again, apart from the interview which I did there.

Q142 Valerie Vaz: Now, in paragraph 129, the last sentence: "In fact, I seem to remember that there were no clinicians present at Mid Staffordshire's Board to Board, which was striking." What did you do about that? What did you say?

Sir David Nicholson: In the letter that I wrote in response to all of that, I said that it would take, in my view, two years for that organisation to become a foundation trust; a critical part of that would be strengthening the relationships between the clinicians and the managers, and they should get a proper medical director in place and make that happen. That is what I said in writing to them. There was a plan that came out of that that was agreed by the SHA and the trust, but, of course, we know I then moved on to my next job.

Q143 Valerie Vaz: Right, okay; so you could not follow it up. Even though you knew there were concerns and you knew they were not running the hospital properly, you didn't follow it up, even though you were in your next job. You didn't tell anybody else.

Sir David Nicholson: Of course I told somebody else and there is a record—there is a letter—that sets it out.

Q144 Valerie Vaz: Who did you tell?

Sir David Nicholson: I copied it to the managing director of the Shropshire and Staffordshire Strategic Health Authority. It was part of the team that was responsible there for delivering the foundation trust process across the whole of the west midlands. That is what they did. The NHS was being reorganised yet again at the time. I, with all of my colleagues, had to apply for one of 10 jobs that were put out. I was—how can I put it?—essentially sent to London to do the London job, and so I went off. But I left pretty extensive plans as to what needed to be done to get that organisation from where it was to become a foundation trust.

Q145 Valerie Vaz: Can I turn to page 53 now, paragraph 166? It is about the appointment of Martin Yeates. I suppose these are the lessons we learn going forward and this is partly why we are trying to find

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out what happened at the time, so please don't be defensive about it all. You say: "I recall that Martin Yeates was enthusiastic about his role. I believe that he had been trying to secure a Chief Executive role for some time, and he was keen to prove himself." You were the external assessor. Were those the only criteria you relied on to appoint him?

Sir David Nicholson: No, no. There was a detailed personal specification. There was a two-day process, which involved a whole series of stakeholders, including the PPI people, all of that, to help us assess the individuals whom we shortlisted, interviewed and then appointed for that. All that is documented—all that detail.

Q146 Valerie Vaz: But that is all you mentioned in your statement.

Sir David Nicholson: It is available. Yes, well, okay, I could have written all of that, but I did not.

Q147 Valerie Vaz: It is very kind of gossipy, isn't it? "He wanted the job so I gave it to him and he was enthusiastic." Those seemed to be the only two criteria that you chose to mention in your statement.

Sir David Nicholson: They weren't the only criteria, and I guess if you read the transcript of the long period that I spent there—

Q148 Valerie Vaz: But this is your statement.

Sir David Nicholson: I know you are trying to concertina all of this into a very short period of time, and I understand that, but you will see that it was certainly more extensive than the way you have described it.

Q149 Valerie Vaz: Paragraph 168: "After the appointment of Martin Yeates I would have"—there is that phrase again—"made myself available upon request."

Sir David Nicholson: Yes.

Q150 Valerie Vaz: Did you?

Sir David Nicholson: I am sure I did. I do not have a letter that says I did that. I make myself available to all chief executives, particularly newly-appointed ones. On reflection, we needed a much more kind of structured approach for new chief executives at the time. Nevertheless, I would have made myself available, undoubtedly, to him. I am a very approachable individual, and I try and support chief executives when they are in difficulty.

Q151 Valerie Vaz: But later on you say: "I do not now recall any of the direct conversations with Martin Yates at these meetings."

Sir David Nicholson: As I say, Martin Yates was one of 53 Chief Executives.

Q152 Valerie Vaz: So even at that time—he is newly appointed—there were no concerns raised at all with you or him about the hospital.

Sir David Nicholson: Don't forget that he had been in post for some time with the chairman before I got there, so he had quite a lot of experience and was seen by everybody in the strategic health authority as part

of the solution for that particular hospital—the bid to take that organisation forward.

Q153 Valerie Vaz: I have not confirmed it—we certainly have it in some of the background information we have received—but, even after he left, you still tried to secure him another position within the NHS. Is that right?

Sir David Nicholson: That is not true. That is not true.

Q154 Valerie Vaz: That is not true. So what is the truth then?

Sir David Nicholson: I was asked whether I thought it was appropriate to secure him a post somewhere else and I said no.

Q155 Valerie Vaz: Isn't that sometimes the problem—

Sir David Nicholson: But that was not the problem in this case.

Q156 Valerie Vaz: Let me finish my sentence. Isn't that sometimes the problem, because there is a feeling that there are people who are moving round the NHS, a bit like you? Even though something happens in Mid Staffordshire, off you go to London, and it is the same old people going round and round.

Sir David Nicholson: I am sure we will get on to me in a while—

Q157 Valerie Vaz: We are on to you, aren't we?

Sir David Nicholson:—but in those circumstances it is true that sometimes people do not succeed as chief executives, not because they are not good managers and could find a role somewhere else, but because they are not suited to become a chief executive. Sometimes that does—

Q158 Valerie Vaz: Who finds that out and when?

Sir David Nicholson: Mainly the chair and the board would be the normal organisation that would do that. In the case of Martin Yeates, he stepped down when the report came out. The chair that was brought in by Monitor and the acting chief executive commissioned a report to say whether he had a disciplinary case to answer. That report said that he did.

As a foundation trust, they balanced off the problems for that organisation if they went through the disciplinary procedure against the cost to the taxpayer, and they judged that it was best to give him six months' pay in lieu of notice. They agreed that with Monitor. The Secretary of State at the time wrote to the trust and said he did not think that was appropriate. Alan Johnson wrote to the trust, but that is what the trust did. So he was removed from post.

Q159 Valerie Vaz: Finally, at paragraph 200—I am just trying to work out the nature of your relationship and your role, which seems to be overarching and overseeing—you referred to "I appointed David Flory" and "I also appointed Sir Bruce Keogh". Is that just you on your own appointing them or is there a board?

Sir David Nicholson: No, no; there was a panel.

Q160 Valerie Vaz: So it is not you appointing; it is a panel.

Sir David Nicholson: I am the officer who makes the decision, whereas, for example, in a foundation trust, or a trust, it is the chair who makes the appointment. In those circumstances, it is me that makes the appointment.

Valerie Vaz: Thank you very much.

Q161 Andrew George: Looking at this issue from a wider perspective and the principles of how responsibility and accountability are discharged, which are partly covered by the more nitty-gritty questions that Valerie has just asked, in your opening remarks you said that the results of the Mid Staffs inquiry had given managers like yourselves the opportunity to reflect—in fact, the need to reflect—on the very grave outcomes and findings of that report. Yet, in terms of accountability, it seems to be only the clinicians—currently there are nurses before the NMC at this moment—who were being held to account. Do you think it is fair that managers have the luxury to reflect and front-line clinicians are held accountable?

Sir David Nicholson: I think I said that the chair, the non-executive directors and all of the directors of that organisation left that organisation relatively quickly after it happened. That accountability played out pretty straightforwardly, as you would expect in the circumstances. So that did actually happen.

Q162 Andrew George: That is where the accountability stops—with them. As soon as they have gone, then that is it.

Sir David Nicholson: The accountability for the quality of services at a hospital is the responsibility of that board. That is absolutely clear and set out. That is the legal basis of that organisation. Of course, Francis then did his inquiry and said that there was a basic system problem out there, which I think there was at the time, and, undoubtedly, it did affect the arrangements in there.

If you are asking me about the issue of the professional accountability of managers, which I think Francis does talk about in terms of whether there should be regulation of managers, if that is where you want to take it, it is an interesting and important question. We need to think about it really carefully.

From my own perspective, it is an odd position whereby, if you sit round a board table as a chief executive, with a nurse director who has a professional accountability, a medical director who has a similar professional accountability and a set of standards they are expected to deliver, a finance director who, again, has those arrangements, and an HR director, typically, who would also have all of those, the chief executive is the only one who does not in those circumstances. So I think there is a case for better regulation and a standard setting for chief executives of boards.

Q163 Andrew George: The report clearly says that there were serious, systematic failings throughout the NHS, which led to the outcomes at Mid Staffs. Indeed, it looks like there were a large number of other hospitals where there were very significant concerns

about excess deaths as well. If there are systematic failings, who is responsible for the system that apparently failed?

Sir David Nicholson: The system that failed was designed in 2005 as part of the Government's response to commissioning a patient-led NHS. It was given to me in my responsibilities to make it work. That is what we have been trying to do. The critical bit of that was not one of structure or organisation; it was one of whether quality was the organising principle. That is the thing that, right from the beginning of my tenure in this organisation, I have attempted to make a reality. You can see a whole series of things I have done to make that happen.

Q164 Andrew George: So it was a political failing; it was the creation of the system politically as a result of the reorganisation in 2005, and it was political decisions which led to the failure.

Sir David Nicholson: If you look at the organisation of the NHS at that time—and obviously I have been involved since the mid-1970s in the NHS—what you see is reorganisation on top of reorganisation on top of reorganisation. What you get out of that is a confusion about accountabilities and a confusion about who is responsible for what.

What you can see in that process is that the people who designed it in 2005 were not trying to create a confused situation, but, actually, when you added it to the other changes that had already happened in the past over the previous 10 years, it created an environment where the clarity of role that you have described simply was not there and the organisations were neither capable of making nor had the capacity to make the change required.

Q165 Andrew George: I put it to you that what appears to have been created—I think the Francis report identifies it and to a certain extent is guilty of it as well—is a management culture that seems to be practised in the arts of management babble, which heaps unrealistic pressure on the clinicians on the front line, and yet at certain tiers of management, and this is really what we need to find out, a blind eye is turned to the consequences of the unrealistic pressures that are placed on that front line. Do you agree with that description?

Sir David Nicholson: I understand the issue and have seen parts of the NHS where that has been the case, but I have seen great swathes of the NHS where that simply is not the case. There is a lot of evidence to support that. But when it happens in that way, it shows—and Mid Staffordshire shows—how quickly you can get into a place where patients are harmed if you do not get the right culture locally. That is true.

Q166 Andrew George: It is quite clear that nurses were reporting inadequate staffing levels and this was happening on a very regular basis at the Mid Staffs level, and yet insufficient or no action was taken. The pressure was on the service, and yet the managers failed to provide the staff because they had to do the system's bidding, and they also had financial targets to meet. Are there not lessons that you yourself and

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those at your level need to learn from that and take forward?

Sir David Nicholson: Absolutely. When I was first appointed to the job, when I came into this particular job, I coined a phrase, which at one level sounds trite but it is really quite an important phrase—“Hitting the target and missing the point.” This is the dangerous place that some organisations got into. Even today, in some places, it happens now where, in a sense, the target becomes—the best example I can give is a conversation with a middle manager and an A and E consultant, which goes something like this: “Move that patient into a clinical decision unit or get them admitted because we will breach the four hours.” That is a bad, bad conversation to have.

Q167 Andrew George: Yes, but you knew that was going on at the time.

Sir David Nicholson: It is a bad place to be. Wherever I see it, in whatever I say, in all of the conversations I have, all the things I do with chief executives across the country, I say that that is absolutely the wrong conversation. The right conversation between a middle manager and the A and E consultant is, “How can we get the best experience for this patient? How can we get them to see the person they need to see as rapidly as possible and make sure that they get a good experience out of it?” Then you think about what you do.

That is absolutely about culture. It is about the way organisations operate, and sometimes—and this case is a good example—the NHS falls short. I do not accept that all the NHS all over is in that culture. There is a lot of evidence, whether you look at the staff survey or whatever, to show that is not the case.

Q168 Andrew George: But, still, you were presiding over a system in which those clinical priorities were being distorted as a result of trying to meet, for example, as you said, four-hour waiting targets in A and E, and you know full well that the pressures, for example, in Mid Staffs were financial pressures. They had targets to meet and a blind eye was turned to the consequences for patient care. You have to agree.

Sir David Nicholson: I absolutely do not accept that a blind eye was turned. If you look at the position of organisations across the whole of the west midlands at that stage, Mid Staffordshire was not on anyone’s risk list of organisations in difficulty. There were a lot of others that were, that we kind of got involved with in much more detail, but that organisation was not, and that was the tragedy of it in a sense. Because we were counting the kinds of things that you have just described—because the system was designed to do all of that—because we did not have access to a whole range of clinical data about that organisation, and because the system as a whole did not take seriously enough at that time the input of patients and their relatives, that is why it happened.

Q169 Andrew George: Who were you accountable to when you were overseeing the SHA and ultimately—

Sir David Nicholson: I was accountable to Nigel Crisp.

Q170 Andrew George: Then who was it when you took over his post?

Sir David Nicholson: I was accountable to Patricia Hewitt.

Q171 Dr Wollaston: Good morning, Sir David. You have talked about all staff within the NHS taking responsibility and reflecting on their own position. Can I ask how far you take personal responsibility for an organisation that has been shown to minimise patient complaints, gag whistleblowers, massage mortality data, bury bad news and, frankly, to lose sight of the patient in the bed?

Sir David Nicholson: Are you referring to the whole of the NHS when you talk about that?

Q172 Dr Wollaston: Yes; all of the issues that are being covered. How far do you personally take responsibility for that?

Sir David Nicholson: First of all, I do not accept the way you have just described the NHS. It is a much more balanced picture than you have described there. Secondly, I have spent 35 years being a chief executive in the NHS. I am completely dedicated to improving services for patients. When I hear bad stories about the NHS, of course I feel responsible. I am like everybody else in that I listen to people, I go round and talk to people and of course I feel responsible for all of that. I have the privileged position where I can try and do something about it, which, it seems to me, is what I need to focus my attention on.

But I do not accept the way you painted the picture. Indeed, it is a real problem for us at the moment—I think we will talk about it in a while—and I am not quite sure how we get ourselves out of this. On the one hand, if I say to you that year on year hospital mortality has gone down in this country, in English hospitals, over the last few years, with some dramatic reductions in some parts, when I say that it is almost as if I deny the appalling suffering that the individuals at Mid Staffordshire had.

Dr Wollaston: Can I stop you there?

Sir David Nicholson: Then, on the other hand, if I talk about the appalling suffering, many people in the NHS say to me, “Why aren’t you saying the good things?” So it is a balanced picture.

Q173 Dr Wollaston: It is a balance, yes.

Sir David Nicholson: That is what Francis says. He says that too often—and this is a big reflection for me—in relation to a complaint or a problem raised about the NHS, our response is “lines to take”, when actually it should be, “Let’s learn from all of this.” I think that is a big lesson for us all, me included.

Q174 Dr Wollaston: I completely accept there is a balanced picture and—believe you me—I am passionate about the NHS as well.

Can I take you back to a statement you made earlier that, when you were at west midlands, where you were responsible for 10 months, the NHS at that time was neither equipped nor capable of monitoring the quality? In fact there is evidence, isn’t there, that staff at West Midlands Strategic Health Authority were

logging on to the data from Dr Foster from 2008 onwards?

Yet the response seems to have been to commission research to discredit the data. In other words, the response was not, on seeing mortality data, "Actually, this is very worrying. What can we do about our hospital?" It was, "Let's see how we can discredit the data." What I am interested to know is this. We are told that the strategic health authority commissioned that, but were you personally aware that that research was being commissioned to try and discredit the data?

Sir David Nicholson: Can I say that I was never the chief executive of West Midlands Strategic Health Authority, just to make that clear? I left in 2006. Nevertheless, it is an important issue. Can I talk about HSMRs a bit now? I do think this is a really important issue, not just for Mid Staffordshire but for the NHS as a whole. Hopefully, Bruce can help me in all this. I do think it is an important set of questions and it goes exactly to the point that you make there.

If you run a hospital—if you are responsible for a hospital—you can look at the number of patients that you treat over a period. That can be over a quarter or half the year, a year or whatever. What you do is you identify what the diagnosis for each of those patients is and then identify what the severity of their illness was. It could be that they were old, so, if you have heart failure and you are in your 90s, the chances are it is more severe than at other ages. It can be that you have other underlying conditions. So, out of that, you get a real picture for the diagnosis of your patients, how many there were and any kind of secondary conditions they have. Then you measure the number of deaths that you have in those circumstances. I am sure you know all this, but I think it is important to do that.

You then take that and compare it against the national average for a similar hospital with similar conditions. Out of that, you can work out whether the number of deaths you have is greater or less than might have been predicted from the model. As you know, it is an average, so quite a lot of hospitals are below, quite a number of hospitals are above, and some are outliers in those circumstances.

The number that it gives you is the number over the average that that organisation experiences. What it does not say is how many of them were avoidable or—in the way it is described these days—unnecessary. Any avoidable or unnecessary death is a tragedy, and we in the NHS need to be focused on minimising that. But to go from that number of excess deaths to saying that they are avoidable is a big step to take.

What we know—and the west midlands is a really good example of this—is that the response very often to that first number, the excess deaths, is headlines that say all these deaths were avoidable, when the only way you can deal with that, the only way you can make a judgment about how many of those were actually avoidable, is to go through the case notes of the patients, talk to the relatives and the staff and understand it all. That is what we offered in Mid Staffordshire for everybody, and over 200 patients took it up. But it is very difficult, even in those circumstances. Now, what happened in—

Q175 Dr Wollaston: I'm sorry, but weren't they right? They were right about what was happening at Mid Staffs, weren't they?

Sir David Nicholson: Yes, but the point I am trying to make is that the obsession with the number, which is the point that you raised, is not the place to go. It is an indicator to go and look. The problem—

Q176 Dr Wollaston: But nobody did.

Sir David Nicholson: Exactly. That is the point I am trying to make. The issue in west midlands is that they got so excited about the number that they did not go and look. That was the terrible thing about the experience in the west midlands in relation to that—and they should have looked.

One of the things that we did—I did—as part of all this, when it became clear that that was what was happening, was that we set out in our operational guidance to all trusts now to look at their mortality data in detail. Your board has to look at it, and just because you are over or under should not give you either a false sense of security or otherwise. Even if you are under the average, you can still have problems in particular, so you have to look at it. What we have said in those circumstances is that, if you are an outlier, the strategic health authority has to be involved and has to go and look. For the last two years that is exactly what people have been doing. But it is an indicator.

Q177 Dr Wollaston: Yes. I asked you quite a specific question about whether you were aware that that research had been commissioned to discredit the data.

Sir David Nicholson: No, I wasn't aware.

Q178 Dr Wollaston: So you were not aware of that. Thank you very much for clearing that up.

Another point of concern is that three reports were commissioned in 2008, probably to coincide with the 60th anniversary of the NHS, all with titles like "Achieving the Vision," "Excellence in Quality," and all that kind of thing. Actually, they contained some rather uncomfortable reading, none of them were published, and they had to be FoI'd in order to see the light of day. Were you aware of the contents of these reports?

Sir David Nicholson: All three of those reports were commissioned by the chief medical officer as part of him writing a report as part of "High quality care for all". So it is part of the process that was gone through in all of that. Until the inquiry raised them with me, I had not seen those reports.

Q179 Dr Wollaston: You had not seen them.

Sir David Nicholson: I hadn't seen them.

Q180 Dr Wollaston: How confident can we be, going forward, when we have reports that are, frankly, very critical—they do highlight many of the issues that then subsequently have come up in the Francis report, yet really very few of them make it into the final document—or how far do you hold yourself responsible for presiding over a culture that tended to bury bad news, with inconvenient truths swept under the carpet?

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Sir David Nicholson: I don't think that is the case.

Q181 Dr Wollaston: You don't think that that is the case. You don't think it is unacceptable that some of the points that are raised in this did not make it into the final document.

Sir David Nicholson: Which particular points were you referring to?

Q182 Dr Wollaston: Where do I start?

Sir David Nicholson: The basic analysis that quality was not part of the organising principle of the NHS and that we were not geared up properly, either to monitor quality or improve it, is at the heart of "High quality care for all". Many of the things, whether it is the way you regulate for quality, measure quality, or the development of the NHS Constitution—all of these things—were done in order to deal with that basic analysis. If you are asking me, having read all of those documents, whether I agree with the analysis that underpins them, some of it I do and some of it I don't.

Q183 Dr Wollaston: But would you think it is fair to reflect that some of the very critical points that were made—things about cultures of fear, doctors distrusting management, all these kinds of things—are not very evident in the final document?

Sir David Nicholson: They are not very evidence-based in the documents either, having looked at them. I did not see them at the time so I can't say—

Q184 Dr Wollaston: You say they are not very evidence-based, but they are very much the same things that come up in the Francis reports—so they were clearly correct.

Sir David Nicholson: No, I am sorry. If you take the JCI report, which is the one I guess you are particularly referring to, that talks about the culture of fear and all of those things. We have the largest staff survey in the world, a properly organised and properly audited survey, which has the highest standards in it. It is not a "ring round" to 50 people, which is what the JCI did. That paints a balanced picture of some problems in terms of culture but not the kind of thing that is described in that document. So I think the evidence does not support what the JCI say in those circumstances.

Q185 Dr Wollaston: Coming on to staff, and perhaps that culture of fear, and the use of gagging clauses against whistleblowers, are you aware of the extent of gagging clauses in the NHS? Is that something that you are personally aware of and what do you feel about them?

Sir David Nicholson: As someone who was personally involved in whistleblowing some years ago, I personally regard this as a really important issue for me. Wherever I see it, or if I have a whiff of it—and I think the Health Select Committee at one of its meetings had a whiff that there was a problem—I immediately intervene in the organisations themselves and tell them what their responsibilities are in relation to that.

I intervene directly with organisations that I feel are not providing the right kind of support to people who are whistleblowing. I have also written out to the service, as you will know, most recently in January 2012, where not only did I say people have a legal duty to do all of this but it is vitally important for patient safety to make it happen. So I am absolutely against them, and, wherever I see them, I try and stop them.

Q186 Dr Wollaston: So you were not aware of the high-profile gagging clauses and payments.

Sir David Nicholson: Whenever I get information about them, I intervene and put them right.

Q187 Dr Wollaston: You intervene and put them right; okay.

Finally—because I know other members are keen to come in—there is the issue about whether or not we tend to minimise patients' complaints. Certainly, looking at an e-mail from Anna Walker, back in 2008 she talks about you describing campaign groups as "simply lobbying". That is a culture that a lot of people feel unhappy about in the NHS.

You have talked about the importance of reading patient stories, but in fact very many people who complain about the NHS come across a very defensive culture, and that would certainly be reflected in what is said in that e-mail. If they are just described as "simply lobbying", they are easy to ignore.

Sir David Nicholson: On that particular occasion, of course, Francis does reflect it in his report. I don't know whether you want me to say what he says in it because I think it is quite important. It says: "Sir David Nicholson's suggestions about CURE in May 2008, if expressed as recorded in Anna Walker's note, would have been inappropriate. However, Sir David has denied that he would have said this or intended to convey such a sentiment, and this Inquiry accepts that whatever he was understood to have been saying he had no intention to convey any disapproval of CURE or suggestion to the HCC as to how it should approach this group."

So Francis dealt with that in his inquiry. In terms of reflections and regrets in relation to all of this, one of the things I do regret very much is that, when all this blew up and the Healthcare Commission was engaged, I should have made efforts to meet Cure—and I did not. I dealt with them through intermediaries, and that was wrong. That is a big lesson for me. It became almost impossible during the inquiry to do it. I have tried afterwards, but, for obvious reasons, they do not want to meet me. For me, that is a kind of regret about what I should have done at that time.

I have a lot of experience of dealing with complaints as part of running trusts and hospitals and all the rest of it, and certainly with the organisations that I ran we had extensive ways of getting patient feedback and dealing with complaints. Those complaints are fantastic fragments of information if you really want to improve your service. It was not any accident to me that one of the problems at Mid Staffordshire was that they had an over-legalistic view to complaints so that they responded in very legal terms. When you look at some of their letters, they are absolutely

appalling, and what must the patients have thought of them? Complaints are really valuable sources of information for organisations to improve services to patients.

Q188 Dr Wollaston: Do you think the NHS has got it right now?

Sir David Nicholson: No. There are lots of places that do it fantastically well and I have been there, seen them and spoken to them. That is why the Government announced the work that Ann Clwyd and Tricia Hart are going to do to lead some work on how we can get best practice everywhere for complaints, because it is so important to take the service forward.

Q189 Dr Wollaston: Moving forward, I know that you have the confidence of the board to manage this very difficult transition period. Do you think, on reflection, that you are the right person to take the NHS forward in the long term, or do you feel that there is genuinely a concern that you could be personally conflicted, in that now we also have other hospital trusts where we are investigating excess deaths?

Sir David Nicholson: I set out before how important it seems to me. I have a duty and a responsibility to manage the organisation over these great changes. I also think that, if you look at my record of what I have actually done, you can see that I absolutely get the changes that need to happen to the NHS. On one of the things that I was responsible for—and you will remember it—“High quality care for all”, Ara Darzi wrote to me as chief executive of the NHS and said, “Should the NHS have a constitution? Should it set out somewhere what the principles, rights, responsibilities and values of the NHS should be? And, if they should have one, what should it look like?” I produced the NHS Constitution, which is a really important document, I think, in the sense that it sets out there a set of values and principles on which you can build the NHS.

Have we done enough? No, we absolutely have not. I do believe that, given my commitment to the Constitution, my understanding of the way the NHS operates, my commitment to patients and the way I can see things like transparency and opening up the NHS, I am absolutely the right person to take that forward.

Dr Wollaston: Thank you.

Q190 Barbara Keeley: Can I touch on those reports that my colleague has just referred to from the IHI, JCI and RAND Corporation? Particularly, there is a quote from one of them—and this is a point rather than a question—“We were struck by the virtual absence of mention of patients and families in the overwhelming majority of our conversations.”

Sir David Nicholson: I did not quite catch the first bit.
Barbara Keeley: “We were struck by the virtual absence of mention of patients and families in the overwhelming majority of our conversations...or any other topic relevant to quality.” I think that is particularly relevant in terms of the Francis report and inquiries that this Committee has done. If those reports were commissioned, they should have been

released, and I think it says something about the culture of the NHS that they were not and they have had to be drawn out of you by Freedom of Information requests.

Sir David Nicholson: I have not seen them myself.

Q191 Barbara Keeley: You are the chief executive of the NHS.

Sir David Nicholson: I agree, and the chief medical officer was asked to do something on all of that. But the point that they make we built into the report, because part of the issue around it—and this may seem a small point, but I think it is a very significant, big point for the NHS—is that everyone was in favour of quality, but everyone thought it meant something slightly different.

One of the things that came out of “High quality care for all”, and particularly those conversations that you described there, was a definition of quality that covers effectiveness, safety and patient experience. You could not have one without the other. It was not possible for clinicians to say that the operation was a success but the patient had a miserable experience. That was not quality. Building patient experience into a definition of quality was really important. Is that fair, Bruce?

Professor Sir Bruce Keogh: Yes.

Q192 Barbara Keeley: It is a very serious thing to say about our national health service that conversations that were held on many aspects of quality did not touch on patients and their families. You said that you had to work through patient stories over a weekend. A weekend does not seem a very long time to me if we take into account the number of cases of low quality of care and the number of deaths, but that is just an observation.

Sir David Nicholson: The patient story thing is really important, because if you take the way I recruit staff to work for me now, one of the things we do as part of the recruitment is that we give them patient stories. Then we talk to them about what they would do in the circumstances they would find themselves in around those patient stories. It is only a small point, but I think it tries to make it alive to people so that when you are recruiting people at the moment you can get their understanding about what those patients might have felt and gone through.

Q193 Barbara Keeley: Can I take you back to your role in driving the quality of patient care, because you told us earlier you had spent 20 years of your life running hospitals?

Sir David Nicholson: Yes.

Q194 Barbara Keeley: At the inquiry, Francis questioned you about where responsibility and accountability for Mid Staffs lay between the trust, the PCT and the SHA. You said this: “Well, both the PCT and the SHA had responsibilities for quality, but the way that quality was measured at the time was relating to access and healthcare-associated infections.” In fact, what you were saying was that it was really just a subset of all the issues and nothing about patient safety and quality of care in those things. It was just

access and healthcare-related infections. In fact, you went on to say: “There was no mechanism... to hold...the trust to account...for the detailed way in which clinical services were managed...We were neither skilled nor capable of doing that.” That is what you said.

I actually find that rather astonishing. It is an astonishing admission—

Sir David Nicholson: It is—

Barbara Keeley: Can I finish? It is an astonishing admission for somebody that was in your role at the time and who is in your role now that you were not skilled to hold the trust to account.

Sir David Nicholson: The difference I would give you is this. I was, as I say, substantively responsible for Birmingham and the Black Country SHA. We had done a lot of work on bringing clinicians into the strategic health authority, for building up our capacities there. I appointed a medical director in Birmingham and the Black Country Strategic Health Authority. It is now astonishing to imagine that most strategic health authorities did not even have a medical director, and some of them did not have a nurse director during that period.

Q195 Barbara Keeley: You said “we”. Do you include yourself in that—that you are not skilled to hold a trust to account? You were not skilled in that way.

Sir David Nicholson: I was referring to “we” as the strategic health authority.

Q196 Barbara Keeley: Did you have the skills and do you have the skills?

Sir David Nicholson: I absolutely have the skills. I have managed hospitals directly; I have managed clinicians directly and all the rest of it. The point I was making is if—

Q197 Barbara Keeley: So why were those skills not brought to bear on the Mid Staffs situation? You said that that accountability did not happen because “we were neither skilled nor capable” of doing that.

Sir David Nicholson: It was one person. If I take the Shropshire and Staffordshire example, there was no medical director. There had not been a medical director in that organisation. There was no mechanism in that organisation to do it.

Q198 Barbara Keeley: How many staff did you have and how many staff did the PCT have? How many staff did you have at the SHA?

Sir David Nicholson: In Shropshire and Staffordshire? I could not tell you that offhand.

Barbara Keeley: What is it roughly—50 or a 100?

Sir David Nicholson: I would have thought about 60 or 70.¹

Q199 Barbara Keeley: What about the PCT?

Sir David Nicholson: I could not give you that information offhand.

Q200 Barbara Keeley: Roughly—100, 200 or 300?

Sir David Nicholson: Genuinely, I could not give you that information.

Q201 Barbara Keeley: But between you, hundreds of staff with probably your sort of qualifications, you were not skilled or capable of holding the clinical management of that trust to account.

Sir David Nicholson: There were very few clinicians in the SHAs operating at that time. One of the things that I did when I became chief executive of the NHS was to insist that every strategic health authority had a nurse director and a medical director. In fact, the NHS did not have a medical director when I was appointed as chief executive, and one of the first things I did was appoint a medical director. We needed clinical capacity in that part of the system to enable us to start to do the sorts of things that you describe.

Q202 Barbara Keeley: So all your experience—your 20 years of running hospitals—does not give you the ability to hold a trust that gets into trouble to account. It does not give you that experience.

Sir David Nicholson: It helps you understand what is happening in an organisation, but unless you have the data and can talk to the clinicians directly—

Q203 Barbara Keeley: You could order up the data. Anybody in your structure, anybody in the PCT, could have said, “We have an issue here. We have a set of issues here. Things are going badly wrong. Let’s not leave it to them. Let’s ask some questions. Let’s get the data.”

Sir David Nicholson: The point is that the data that was available to the PCT, to the general practitioners, to the regulators, to all of those, did not indicate at that time that there was a problem in that organisation. Now we might wish it was different, and it is different today—there is a lot more data, a lot more knowledge and a lot more information—but at that time there was not.

Q204 Barbara Keeley: Let me take you back again to the question of whistleblowing. Substantial time was given at the Francis inquiry to whistleblowing. Of course, much has been written about it in recent weeks. Francis said that whistleblowing is only necessary because of the absence of systems that welcome the internal reporting of concerns. You have, in fact, touched on staff huddling together and having a grumble, though I think the issues were rather more serious than staff huddling together.

Sir David Nicholson: No, I agree.

Q205 Barbara Keeley: Concerns have to be raised externally if they can’t be raised internally. What did you do when you were chief executive of the strategic health authority, and what do you do now, as chief executive of the NHS, to support clinicians and managers to raise the essential issues about the quality of patient care? What have you done and what are you doing?

Sir David Nicholson: There is a whole range of things around all of that, from making sure and clear that each organisation understands what their responsibilities are, to making sure that every

¹ Note by witness: There were 75 core staff at the newly created West Midlands SHA during this period.

organisation has a proper policy in place that makes that happen, such as setting up the various helplines that have been set up in the NHS to help and support people to do that.

What I would say is that the staff survey results give you an indication that we are making some progress here. So the actual outcome of it, I think, is that we are making progress. We are by no means at the end of this journey at all, but, if you think about the statement, "My trust encourages us to report errors, near misses and incidents," in 2006, 76% of the staff agreed with that and today it is 86%.

So there has been improvement over the period and people feel that they are doing that. It is not enough, and we need to get it much better than that, but that shows, in practice, on the ground, whatever it is, that we are trying to create an environment here and it is working in those circumstances.

Q206 Barbara Keeley: Okay. In what way do you think it is ever acceptable to use confidential gagging clauses and compromise agreements with staff who are departing—we have talked earlier about some staff departing—backed by very substantial amounts of taxpayers' money? For example, £500,000 was reportedly spent on a gagging clause at United Lincolnshire Hospitals Trust. You talked earlier about clear accountability at every level. What accountability have we got if this organisation, the NHS, any part of it, pays somebody £500,000 when he was lining up to expose issues of patient safety at an employment tribunal?

Sir David Nicholson: It is completely and utterly unacceptable.

Q207 Barbara Keeley: You feel that is unacceptable.

Sir David Nicholson: It is completely and utterly unacceptable.

Q208 Barbara Keeley: So in no way did you sanction that, agree to that or think that was right.

Sir David Nicholson: I would never sanction anything of that sort.

Q209 Barbara Keeley: You did not in this case.

Sir David Nicholson: I did not—

Q210 Barbara Keeley: That is the case of the United Lincolnshire Hospitals Trust.

Sir David Nicholson: I understand you are going to talk about this in a bit more detail and the SHA are kind of setting out their responsibilities, but from my perspective—and this is at the nub of where we are getting ourselves into difficulty in understanding all of this—in my letters to the service and in the general way that I have conducted myself I have made it absolutely clear that it is unacceptable, and also illegal, for organisations to gag people around issues of patient safety and improving services to patients. It is completely and utterly unacceptable. The trust itself, as you know, denies that it did that, and no doubt you will have all that conversation when you see the individual.

However, there is an issue about the way in which compromise agreements are developed in the NHS.

When the confidence breaks down between an employee and an individual, there are normally two ways in which that resolves itself. One of them is that there is disciplinary action taken, and that takes its course, but what happens in those circumstances is that people have to have due regard to the interests of taxpayers.

So, in some circumstances, organisations take legal advice and make a judgment that it will be in the interests of taxpayers to sign a compromise agreement. That compromise agreement should never, ever exclude people speaking out on patient safety issues. Absolutely, if we find any of that, we need to absolutely eradicate it. That is how not just the NHS but the world works. What has happened is that in some cases—not necessarily the Lincolnshire case—those two things have been confused.

Q211 Barbara Keeley: Where is the level of sanction for an award of £500,000 for somebody who was lining up to talk to an employment tribunal about patient safety? Where is the sign-off for that?

Sir David Nicholson: There is a whole series of things that you have said there that are bitterly contested and I do not want to get into that particular case.

Q212 Barbara Keeley: I have asked a question. Tell me where the sign-off is.

Sir David Nicholson: The arrangements at the moment are that, whatever the agreement is, it is a legally binding agreement between the individual organisation and the person involved. It is their statutory right as an employer to do all that.

Q213 Barbara Keeley: Where is the sign-off for the £500,000?

Sir David Nicholson: I am just going to come to that. The arrangement we put in place is that the sign-off for that is the strategic health authority remuneration committee. So it goes to the strategic health authority; this is for non-foundation trusts, I have to say, because it is different for foundation trusts. For non-foundation trusts, it goes to the remuneration committee of the strategic health authority; they look at all of that and they have to look at their compliance and all the rest of it. Then what they do, in those circumstances, if they think it is all above board, in the taxpayers' interests and there is no gagging clause, is refer a business case to the Department of Health.

Q214 Barbara Keeley: So again, this one came to the Department.

Sir David Nicholson: This one actually did not. I will get on to that, but this is the process we have in place. It goes to the Department of Health, and then it goes to the Treasury to sign off. But the business case signed off by the Treasury relates to the interests of the taxpayer in all of this. The case in Lincolnshire was different. They went for a different arrangement, which—if I can get the title right—was a judicial mediation. In those cases, they do not have to get signed off by the Department and the Treasury.

Q215 Barbara Keeley: How convenient.

Sir David Nicholson: Pardon?

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Barbara Keeley: How convenient.

Sir David Nicholson: Well, I am just giving you the answer to the question.

Q216 Barbara Keeley: What do you think, as chief executive of the NHS, of a loophole like that existing—where £500,000 of taxpayers' money could be used to gag somebody who wanted to talk about patient safety?

Sir David Nicholson: As I say, the comments you make there are bitterly contested by the organisations involved—bitterly contested.

Q217 Barbara Keeley: What do you think of that as a use of taxpayers' money?

Sir David Nicholson: In terms of the judicial mediation, it is the first time in my experience that I have ever seen that done. I have asked around and I do not think there is another example of that at all. If it is a loophole to get round the Department, then it needs to be closed and we need to think about how we might do that.

Q218 Barbara Keeley: Are you doing that?

Sir David Nicholson: We will absolutely do that to see what it is. It may not be possible, legally, to do it, but not giving the ability for the SHA remuneration committee to sign it off and for the Department and the Treasury to sign off the business case seems to me wrong.

Q219 Barbara Keeley: So no one signed that off apart from the trust. In the NHS, no one signed off that use of the £500,000.

Sir David Nicholson: It certainly did not come to the Department of Health and it didn't come to the Treasury.

Barbara Keeley: I see; okay.

Q220 Chair: Can I ask a specific question about the Francis recommendations on the use of public money? You rightly say that compromise agreements have quite a widespread use in the private sector. There is a difference, isn't there, where it is public money that is being used to achieve agreement in a compromise agreement? Do you agree with Francis that there should never be any circumstances where payments made in the context of a compromise agreement are kept confidential?

Sir David Nicholson: I do not understand the legal consequences of all that, but it seems to me, in terms of transparency and openness, that that should be the case.

Q221 Chair: In principle, fish-and-chip meals invoices appear on the website, and yet we spend hundreds of thousands of pounds and it is bound by a confidentiality agreement. That must be nonsense, mustn't it?

Sir David Nicholson: For transparency purposes, it must be wrong.

Q222 Barbara Keeley: Can I take you back to what has happened in recent weeks as a follow-on from all of this? The NHS issued management directions in

1999 and 2004 on the use of gagging clauses, but it has been necessary, it seems, in recent weeks—particularly in terms of whistleblowers like Gary Walker being able to talk, for instance, to us as a Committee—for the Secretary of State to write to trusts to remind them of their obligations not to inhibit protective disclosures.

Why is it, given everything you have said about your interest in transparency, that bodies such as Patients First consider that their members are still prevented from raising concerns about patient safety? This absolutely goes to the heart of issues at Mid Staffs and the other hospitals where there are issues, as there was in the case of the United Lincolnshire. How is that the case?

Sir David Nicholson: Well, you had better ask them.

Q223 Barbara Keeley: You have an ineffective issuing of guidance and ineffective processes. You have £500,000 gags being put on people to stop them going through an employment tribunal and revealing information that is presumably inconvenient. How is this happening? It just seems that the NHS is completely ineffective at dealing with this.

Sir David Nicholson: Again, I have to say that what you say about Lincolnshire is bitterly contested. Obviously, I do not want to go into the detail of that because you are going to have the opportunity to do that yourselves.

To keep repeating the fact like that does not help, but, as to the general point that you make, I think, in the vast majority of cases that we look at and work through, the kind of clauses that you have described do not exist to stop people talking about patient safety. But, even if they did, people have the protection of the law and will have the support and protection of the Department and myself to enable them to speak out on patient safety issues, even if all of that does not work.

Q224 Barbara Keeley: In the case of this particular one, because we will have the chance to explore it further, was it the case that, at the point where the person wanted to go ahead and there was a radio interview being taped, the person was being warned off and the Department was involved with that? The Department and the trust were involved in warning off that individual. How do these things happen?

Sir David Nicholson: I absolutely and categorically deny that the Department warned off any individual from doing anything. What happened in those circumstances—and this is part of the public record and the *Today* programme would recognise it—is that the programme rang the hospital and asked them what they thought about that individual going on.

The response of the hospital was wrong. They should not have got their lawyers to write to him to say that he should not talk about that compromise agreement. In the strict legal sense, he had signed a compromise agreement about the resources and what he was doing, but it was not covered. It was absolutely right, free and proper to speak out. If he feels he has something about patient safety to say, then he should be able to say it, and, if the hospital by accident—I do not know whatever arrangements happened at the hospital—put

that letter out—they were wrong to do it. The spirit of it was wrong.

Q225 Barbara Keeley: My question was about the fact that the NHS issues management directions and yet it is ineffective. We have this sort of situation developing, we have had that sort of money paid out, and we have people being warned off speaking out about patient safety. Patients First say their members are prevented from raising concerns, so it is a bigger issue than just the one. The one is an example, but it is a much bigger issue.

Sir David Nicholson: If they want my permission to speak out, then speak out, because we will protect them in whatever way we need to.

Q226 Barbara Keeley: But the message has not got through.

Sir David Nicholson: Okay. Well, hopefully this Committee is an important part of it, and everywhere I go and everything that I say in relation to this reinforces this issue.

Chair: I would like to dwell on this for a second.

Q227 Valerie Vaz: I wanted to ask you, Sir David, that, if there are any gagging clauses out there for members of staff, members of the NHS, who are the subject of gagging clauses, do they write to you?

Sir David Nicholson: If they believe that the clause that they have stops them speaking out about patient safety, they can write to me.

Q228 Valerie Vaz: That is any gagging. You have said—you were categorical—you think they should not exist.

Sir David Nicholson: Yes.

Q229 Valerie Vaz: So, if they exist, they should write to you and let you know.

Sir David Nicholson: If it stops them talking about patient safety, absolutely.

Q230 Valerie Vaz: I want to turn to Francis's recommendation at 179 where he says that they should not exist. Do you have a timetable for that particular recommendation?

Sir David Nicholson: They should not exist now.

Q231 Valerie Vaz: I understand that, but Francis has made a number of recommendations, and in that particular recommendation he said they should be banned.

Sir David Nicholson: They are.

Q232 Valerie Vaz: Do you have a timetable to write to everybody to say that they should not exist?

Sir David Nicholson: The totality of the Government's response to all of those things in there will be coming out at the end of March. Part of the Government's response will be to take on this very issue.

Q233 Chair: Can I ask you to enlarge a bit on this question of what is the scope of a potential confidentiality clause? It is very striking that the

discussion is about people being free to raise concerns about—and the key phrase is—patient safety. There will be many people working in the health service who think they have a concern about the quality of care more broadly defined and who do feel themselves inhibited in speaking out when quality objectives of the NHS are not being met. Do they have the same assurance from the chief executive as somebody who is concerned about patient safety?

Sir David Nicholson: Yes.

Q234 Chair: So there is no magic in this phrase “patient safety”.

Sir David Nicholson: No.

Q235 Chair: It is “quality” more broadly defined in the NHS Constitution.

Sir David Nicholson: Absolutely; that is how you get change to happen. If people do not feel they can speak out, how do you make progress? It is really important. For most staff, in most circumstances, that is exactly what happens. They feel that the organisation encourages them to report incidents and all the rest of it, and it is absolutely the right culture we want to produce.

But, at the other end, there are people who believe they have to go through a whistleblowing process in relation to all of that and we should give them maximum protection. We should nurture them because we can learn from them.

Q236 Chair: But, as Francis himself makes clear, if the culture is right, the whistleblower is redundant because every employee feels encouraged—empowered—to raise broad-based concerns, where necessary, about patient quality rather than just patient safety.

Sir David Nicholson: And the staff survey reflects that.

Q237 Barbara Keeley: Can I finish off the points I was making by saying that, if we are looking on this Committee further into whistleblowing, which we will be, it would be very helpful to have some information from trusts across the country of the level of pay-out that there has been on such agreements. Presumably, as the chief executive of the NHS, you can gather that for us.

Sir David Nicholson: We have it available. I think we have published it already, but, yes, I am very happy to give you any information you require on that basis.

Q238 Dr Wollaston: I have a further point. If they want to whistleblow about something that is just inconvenient for management rather than maybe a direct safety issue for patients—they are often loosely aligned, as you have pointed out yourself—could these people who are subject to these gagging clauses now be confident that they could raise those issues?

Sir David Nicholson: I am expanding the scope here, in a way. I can absolutely go with patient safety and quality. It seems to me that that is a really important part of that. As to the issue about inconvenience to local managers, I am not sure how you would define that. Apart from anything else, that might strike at the

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heart of what the alternative is between going to law or going through the disciplinary arrangements or whatever.

Q239 Dr Wollaston: But you yourself said, when we talked about your three bullet points for improving the future, that high-performing clinical teams measure things and benchmark themselves against other teams. But similarly that must apply to management. There may be things that actually expose management as poorly performing against other managers, and management is very closely linked to clinical performance. So should we not just get rid of these clauses altogether, particularly as we go forward, because all these organisations are going to be individual? Who is going to be holding all these hospitals to account?

Sir David Nicholson: The general kind of move here to transparency is an important part of all this, so I would be wide in my extension of what was suitable. I just think, presumably, at some stage there is some kind of ring to run around it because—

Q240 Dr Wollaston: Aren't they in the public interest?

Sir David Nicholson: Absolutely. Anything that is in the public interest—that could be about the use of resources; it could be all sorts of things—I think needs to be out there and people need to be able to talk about it and to whistleblow if that is what they require.

Q241 Chair: Francis makes it clear, doesn't he, that confidentiality clauses in compromise agreements are appropriate—definitely and clearly appropriate—where they protect knowledge, for example, about individual patient cases? So it is a question of the scope of a confidentiality clause.

Sir David Nicholson: That is why I was slightly worried about—you described it as management inconvenience, but it could, in other circumstances, be something else. But the general point—

Q242 Dr Wollaston: We can all see the difference between exposing intimate patient details and exposing something that is inconvenient about hospital management. I think there is genuine concern, as we move forward, about how accountable these trusts are going to be. We all have to have confidence that members of staff who see things that do not look or smell right have the confidence to raise them.

Sir David Nicholson: I completely agree with you.

Dr Wollaston: Thank you.

Q243 David Tredinnick: Sir David, I want to ask you some questions about Francis's recommendations, starting with statutory duties.

Before I do, I would like to take you back to your opening remarks, if I may, when you said that the NHS at the time was incapable of monitoring what happened at the trust. I put it to you that the most fundamental statistic that you could look for as a manager would be the death rates in your hospitals—whether they were, as you pointed out in questioning from Dr Wollaston, avoidable deaths or other deaths. It was an absolutely basic statistic.

However poor the reporting structure in the NHS at the time was, there was a reporting structure and you had personal judgment. You could perfectly easily have been in there and said, "I want that information," and the structure was there to obtain it. Is that right or not?

Sir David Nicholson: The information that we collected comes through the Health and Social Care Information Centre. That is the basis on which information is collected and that is the way that we use it as we take these decisions. At the time, this information was not freely available in the NHS. It certainly was not freely available to the strategic health authority.²

Mortality rates, as a crude measure, were not part of the way in which anyone measured the way in which the NHS was operating at that time because they beg more questions than they answer. The answer was that it was not available, we did not use it and nobody was using it across the pack at that particular time. In hindsight, that seems extraordinary—I absolutely take that point—but we have put all of that right.

Q244 David Tredinnick: You also said that you got so excited about the numbers that you did not go and look. I find that quite extraordinary. How can you possibly look at a set of numbers that tell you a story and use that as a reason for not investigating the circumstances?

Sir David Nicholson: I agree, and that is the point I was making. The strategic health authority at that time, and the trust, looked at those numbers and said they did not trust the numbers. They then instituted a whole set of investigations to look at those numbers in a different way—and they were wrong. We have put clear guidance to organisations over the last period to ensure that people do go and look—not only the board, but also the external body, the strategic health authorities in this case. More recently, Bruce and his investigating team are going to go and look.

Q245 David Tredinnick: I put it to you that what occurred—and we have had this massive report—was not a failure of process but actually a failure of top management to make proper assessments within the current arrangements.

Sir David Nicholson: That is not what the report says.

Q246 David Tredinnick: I am not going to pursue that because we have other questions to go on to.

One of Robert Francis's recommendations was that there should be an introduction of a statutory duty of candour with criminal liability for breaches—a statutory duty, in other words, that those in authority in the health service should be straightforward and honest. Do you agree with that?

Sir David Nicholson: The Government will be publishing their response to Francis at the end of March and Ministers are still considering this as a set of issues. However, I do think the spirit of it—that we

² Note by witness: HSMRs were not part of the set of indicators made available to Sir David as an SHA Chief Executive in the routine performance management of trusts. Although around at that time, they were not yet established as an indicator of quality as their usefulness or otherwise was still widely questioned within the clinical community.

should have a duty of candour—is absolutely right. So I have arranged to be written into all the contracts signed by NHS providers and those outside the NHS as part of the contractual arrangements for next year that they should have a duty of candour that will use contractual arrangements to put into place. As to whether the Government finally decide to give it legal backing, that will come later.

Q247 David Tredinnick: Do you think that it will genuinely encourage a culture of frankness and openness?

Sir David Nicholson: I think it sets an expectation, which I think is a really important point.

Q248 David Tredinnick: How else would do you do it if you don't do it in that way?

Sir David Nicholson: We are putting in contractual arrangements. That is what I am doing. Organisations now are contractually obliged to fulfil that duty of candour.

Q249 Chair: We have been delighted about that since that is exactly what we recommended ought to happen when we reported on the complaints process about two years ago.

Sir David Nicholson: Yes, sorry, absolutely. So that is what we have done.

Q250 David Tredinnick: Robert Francis—going to another subject—told us that he had done his best in his recommendations to ask for as little change as possible in the NHS system, while, in so doing, insisting that measures that put the patient first rather than the system's business be included. Do you agree with that?

Sir David Nicholson: Yes, I do.

Q251 David Tredinnick: What is your assessment of the change required in the NHS system to implement the Francis recommendations in full?

Sir David Nicholson: Do you mean the totality of them?

David Tredinnick: Yes.

Sir David Nicholson: It is a significant change programme for the NHS from, literally, top to bottom. It is setting out basic standards that patients and everyone can understand, and then assessing and inspecting against them. It is the introduction of a whole range of things that the chief nursing officer is leading around the changing way that nursing operates. It is rethinking the way in which we train, educate and bring forward our leaders. It is providing more information to patients around individual consultants' performance and outcomes. It is giving patients better access to their records. It literally is from top to bottom of the NHS.

Q252 David Tredinnick: Is that the kind of advice you will be giving to the Secretary of State and the Prime Minister?

Sir David Nicholson: Absolutely. It is completely consistent with the general approach that I have certainly believed for many years in the NHS. What

it shows, though, is how difficult that is to do and what a challenge it is to make it happen.

Q253 David Tredinnick: How important is giving patients choice in all of this?

Sir David Nicholson: Giving patients choice is an important part of giving them control. If you think about the challenges facing us, a critical part of that is patients taking more control of their health, of their healthcare and of the way in which they work in the NHS. So the idea of choice as being something that you do over here for elective care is a relatively narrow definition of choice. We need choice in all sorts of ways, whether it is through general practice or choice of treatment. All these things are just as important, and we need to make that part of the NHS going forward.

Q254 David Tredinnick: So do you say more responsibility as well—patients taking more responsibility?

Sir David Nicholson: Yes. One of the greatest challenges facing the NHS is the number of people with long-term conditions—diabetes, asthma and all of those.

Q255 David Tredinnick: Like obesity.

Sir David Nicholson: It is all of those sorts of things and the way we tackle them. If you consider that the average person with diabetes will spend, on average, about six hours a year with a health professional and 99.9% of their time not with a health professional, it is that time and how they use it, and the way they control their own health and healthcare, that is the determinant of whether and how successful we are in all of that.

Q256 David Tredinnick: I have two further questions. Robert Francis has recommended the introduction of a set of fundamental standards of safety and quality of care to be applied throughout the NHS, together with provision for enhanced quality standards and developmental standards to be set locally. What is your view on that?

Sir David Nicholson: I agree with that absolutely. The point that he particularly makes, I think, about the basic standards that he is talking about is that they are well understood by patients and the public as well as the regulators, because at the end of the day you cannot have an inspector and regulator in every ward and every department. Patients and their relatives need to be part of this process. Unless they can understand and the standards are meaningful to them as individuals, it is very difficult for them to be engaged. So it is very important that we get the right kind of standards that are understandable to patients.

Q257 David Tredinnick: Finally, earlier in the session, you said that the NHS was at a critical time in the next few days. Do you think, on reflection, that the Commissioning Board is too powerful, too large and too unwieldy?

Sir David Nicholson: No, I do not think that.

Q258 David Tredinnick: Can you explain why?

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Sir David Nicholson: Yes. I do not think that is the case. If you think about most of the commissioning, it is done by clinical commissioning groups at a local level. There are a whole series of differences in the relationship between clinical commissioning groups and the Commissioning Board, as compared with PCTs and the centre.

We have a duty of autonomy, so we have a responsibility to ensure that those clinical commissioning groups are given the freedom that they need in order to meet the health needs of the local population, and they do have most of the resource for the NHS. Power, I think, in those circumstances lies absolutely with the clinical commissioning groups.

We see the NHS Commissioning Board as a way of supporting them to be the best clinical commissioners that they can be. If you set your stall out from that perspective, I think you get away from the idea of having some kind of central power and localised delivery system. It is very much the other way round.

David Tredinnick: Thank you very much.

Q259 Andrew George: As you go through the transition from NHS chief executive to chief of the NHS Commissioning Board, I get an impression of how you perceive the role of the chief executive of the NHS—a role that you will be leaving behind—from the answers you have been giving today.

On the one hand, if there is a systematic failure, then you offer the hospital pass, as it were, to the politicians for having created the environment in which those systems are failing through reorganisation. You also seem to accept my view that there was a culture within the NHS that heaped unrealistic pressure on the front line and turned a blind eye to the consequences. That seems to be that the buck is further down below the responsibility of that of the chief executive. Is there a need for a chief executive of the NHS if the chief executive seems to have no responsibility at all?

Sir David Nicholson: I certainly did not agree with the bit about the blind eye and the rest of it. I said there were bits of the system where that happened, but I did not accept that as a definition of the whole of the NHS and the way it operates.

But there is a difference—a change—in my responsibilities. If you think about the job I have at the moment, I am accountable to a politician. I certainly did not want to leave you with the impression that I was heaping anything on the politicians about the design of the system. The point I was making was that it was being built on a set of other organisational changes on the back of other organisational changes, which very often were outside the time scale in which politicians might be thinking about the reforms of the NHS. So I was not saying any of that.

As the chief executive of the NHS, I think the mandate set out by the Government is a really powerful accountability document. That document, for the very first time, sets out exactly what is required by the Commissioning Board and from the chief executive of the Commissioning Board itself. That is the accountability document that I think has been missing in the past. We have never quite had that

sharp accountability, which I think we do have now in this new role.

Q260 Andrew George: Looking back to where we were with the Mid Staffs situation—your “Sir Humphrey” role, in effect—what were you saying to the senior politicians who had created a system that was clearly failing? You seem to be saying at the moment that you knew that it was a systematic failure. What conversations did you have?

Sir David Nicholson: What I was saying—I said this at the time, and I said this publicly at the time—was that the last thing the NHS needed in 2006 was another set of reorganisations. Even though it was not perfect, and even though we did not want to go through a set of reorganisations, it was a consistent argument that, when I worked with Alan Johnson and Andy Burnham, we held on to quite strongly. Reorganising the NHS is a very difficult thing to do and it is fraught with risk.

Q261 Andrew George: So, by your own standards, you failed. It has gone through multiple—

Sir David Nicholson: I am just saying that was what happened. There is no doubt that the financial circumstances that the NHS finds itself in going forward changes the way in which we need to think about all of that. It was really clear to me in 2008–2009, when we started to think about what the NHS would need to do in a world where there was very little or no growth, that we simply could not afford the infrastructure that we had. We could not afford 150 PCTs and 10 SHAs and all of that.

As part of our solution, we had to radically change that. We also had to make sure that we embedded clinicians in leadership positions in terms of how we would take the service forward. The NHS system needed to change in all of that, and, of course, the coalition Government came along with a set of proposals.

Q262 Andrew George: A hospital I know that you should remember visiting, a fortnight ago, is the Royal Cornwall Hospitals Trust. Indeed, you came through the smaller part of that trust, the West Cornwall hospital in Penzance in my constituency, so thank you for coming.

You will know that at that trust staff morale is at rock bottom, that the latest report is showing that they believe there are significant safety issues within the hospital because of poor staffing ratios within the hospital, and yet the big obsession is seeking foundation trust status. It is quite clear that the message from above to that trust is that it must hit not just a recurring balance but pay off a legacy debt. Armed with all the knowledge and having had the opportunity—using your words—to reflect on the Mid Staffs situation, just in terms of taking the lessons that have been learned, isn't that a recipe for another Mid Staffs?

Sir David Nicholson: You are right that I visited Cornwall a couple of weeks ago. That whole NHS organisation has been on a big journey of its own and I was really impressed with the stuff that was going on in Penzance. It is really interesting,

ground-breaking stuff that is going on in relation to clinical services there, and I was impressed with the people that I met there.

If you think back to the position on Mid Staffs and their wanting to become a foundation trust, in a sense why shouldn't they want to become a foundation trust? It seems to me that being accountable to your local population is a really good thing for an organisation, but, to be accountable, you have to be able to show that you are both clinically and financially viable going forward. You have to take the decisions and make sure that the patients are treated properly in those circumstances.

But, also now, we have introduced over the last few years, under the leadership of Bruce, a whole series of clinical quality bars that people have to go under. So it is no longer the case, if it ever was—but it is certainly no longer the case—that you can drive to foundation trust status and ignore quality. You have to do both of those things together.

I was very impressed with the people who were there. They were not deniers; they did not say they had no problems—they recognised the problems that they have and they are trying really hard to put them right. The most important thing for them is to put those problems right, and that is what I said to them. The most important thing is to get those issues right. In a sense, foundation trust status will take care of itself. If you can become clinically and financially viable and you can demonstrate to your patients that you are providing great services, being a foundation trust is of secondary importance.

Q263 Andrew George: The lessons learned, both in that hospital and indeed throughout the country, are that you will ensure—indeed in your new post you will ensure—that the obsession with the tick-box, target-meeting and meeting financial targets will not become supreme over issues of patient care, and you will absolutely commit yourself to that.

Sir David Nicholson: Absolutely. Hitting the target and missing the point is as true now as it was then. The thing we have learned from the foundation trust is, first of all, to make sure that clinical quality is up there when you are making your judgments, and, secondly, do not have unrealistic timetables to push people through.

Q264 Andrew George: The issue that is underlying this and found in the Francis report is the culture of fear, which was clearly identified within the service in Mid Staffs. Indeed, you must know full well that Mid Staffs is not the only place in which that culture of fear exists, and yet in your own evidence—in your statement to the Francis inquiry—you say that you do not accept that such a culture exists or existed. Do you go around with your head in the sand? Everyone knows that there is a culture of fear in the NHS.

Sir David Nicholson: I certainly do not, and I see a lot of the NHS and have very frank conversations with people in the NHS. There is little point in me wandering round being falsely reassured. It does not work. I am under no illusions as to the stresses and strains that people are faced with. If you think about what it is like running a big acute hospital at the

moment, it is very tough to do that when you think about how you have to balance all the responsibilities that you have on the one hand and be open and transparent on the other. It is very tough things that we are asking people to do.

I get all that anecdotal evidence and I understand all of that, but, if you look at the best indicator that we have at the moment, which is the staff survey, it gives you a much more balanced picture about what it is like to work in the NHS today. It is not saying it is easy, by any stretch of the imagination, and there are some places where there are real problems that we need absolutely not to flinch away from putting right, but overall I do not accept the overall charge.

Q265 Andrew George: In the Mid Staffs report it was quite clear that Helene Donnelly reported through her Datex on nearly 100 occasions about understaffing in her ward, and yet nothing was done about it. She gave up because they all went unanswered.

You know that that is not the only occasion and the only place where that is happening. How will you make sure in future that front-line staff—particularly registered nurses on wards—who want to maintain their professional standards, who actually care about their patients and want to make sure that the staffing ratios are adequate, are going to be listened to when they report inadequate staffing levels?

Sir David Nicholson: Yes. This is a really important issue, I think, and I do not know whether Liz wants to say anything about it. From my perspective, evidence and transparency are the watchwords here, because what Francis says—and I absolutely agree with him—is that we need to use much better what the evidence shows us about what are the right staffing levels for a particular ward, and we need to set that out. We should set out what the minimum staffing level is for each individual ward by using whichever tool that you use, and then we hold the organisation and everybody to account through that.

Liz Redfern: Yes. You mentioned Royal Cornwall earlier, and, of course, you are seeing there, I am sure, a huge cultural change because of visible good leadership through the chief executive, who happens to be a clinician, who goes out and about and gets people to talk to her. I think that is extremely encouraging.

The way we can change culture and leadership at every level, including down to the ward sister in a hospital setting, is absolutely crucial. I agree with David that it would be almost arrogant for anybody in a senior leadership position like mine to set, from a distance, what the levels need to be on a ward. It needs to be a local judgment based on good tools to see what is appropriate here for this staffing skill mix and this type of ward layout for these types of patients.

Q266 Andrew George: And that those are transparent.

Liz Redfern: And that those are transparent. I believe it should be reviewed at the board, using those tools at least twice a year in public, and the trust investment needs to move around in order to fulfil the various requirements, which will be changing all of the time

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in your average hospital or community team. It cannot be something we can set centrally. It has to be a local decision, well supported by leadership.

Q267 Chair: Would you also say engaging commissioners in making that decision?

Liz Redfern: Commissioners obviously need to be involved in that. Commissioners themselves have clinical leaders as part of them. It needs to be a conversation through all those key parties to decide how we are going to provide and commission care the best it can be for our patients and public locally. That needs to be a joint conversation, getting all of those things in place, and then commissioning appropriately and money flowing with that.

Sir David Nicholson: Commissioners have to be interested in staffing levels. If you accept that well supported and well staffed organisations provide great outcomes for patients, you have to be interested in that.

Chair: Absolutely. I agree, but I just wanted to check.

Q268 Barbara Keeley: Going back to the Francis issues around patient-staff ratios, there are some horrendous examples there of people spending long periods of time hunting down a nurse. That seems to be what it was; patients left in soiled bedding largely because there was nobody available to help toilet them; patients falling—very many examples of patients falling—and making their condition worse. That is where we are with that.

Francis has said that the issue was the prioritisation of financial performance over those considerations of adequate staffing, which my colleague has just been touching on, and you have talked about local judgment with good tools. But the CQC tells us that 17 hospitals—it might be more than that, but they have talked about 17 hospitals—currently have inadequate levels of staff to provide safe levels of care. So we are in a situation where we have historic problems with the Mid Staffs issue, where it is quite clear that the staffing was woefully inadequate, and yet we have 17 hospitals that the CQC says currently have those problems.

The question is should we move—as Francis suggests we move rapidly—to a procedure to establish what each service requires in terms of staff members and skill mix. In fact, I have looked at a local hospital that is one of the safest hospitals in the country, and it has a higher ratio of staff to patients. But every time I ask questions here about it, we seem to get this wriggling going on—“Oh, well, it is also a question of leadership.” It does not seem to me that it is a question of leadership. Absolutely at base, it is about getting these ratios right, and if you do not get these ratios right things start to go wrong.

I was reading yesterday on social media an account of somebody who was not attended to overnight. They talked about one or two staff and maybe one healthcare assistant available overnight, with people left for long periods of time. Stories are coming in to us all the time that this is happening. The CQC is saying we have a number of hospitals where this is the case. All of this theorising about developing tools and “commissioners must take account of it”—they

are not. It is an urgent thing to us here that something gets done about this.

Liz Redfern: Could I say a couple of things about that? One is that the 17 hospitals that were previously referred to by the CQC as having poor standards of staffing are not currently in that position. Many of them have been revisited by the CQC and been found to be safe. So it is not a current situation.

Q269 Barbara Keeley: But they were in that situation.

Liz Redfern: They were at that time, absolutely, and actions were taken.

Q270 Barbara Keeley: Stop on that point, though, because if we are not clear about this, if there is no procedure, no mechanism, then 17 more could be appearing. The CQC is quite behind in its workload, as we know from talking to it on other issues, so we cannot regard fixing the 17 that it last complained about as getting rid of the issue.

Liz Redfern: No; I am just making a factually correct statement. I am certainly not theorising about anything. I am not a theorist; I am a very practical person, who has been a nurse since 1970. I have worked in very many settings and seen over those 43 years the situation, particularly in acute wards, changing dramatically in terms of the environment.

All I was saying was that the issues of leadership are important, to support ward sisters, to support directors of nursing on trust boards, to get those numbers right in their local context on a day-to-day basis. They need to be aware of all those examples that you have read on social media and responding to them. You respond on that—

Q271 Barbara Keeley: But clearly they are not, are they? Let us just be clear about it. I do not think going into denial about the state of things is helpful. We have this historic issue at Mid Staffs, which was an absolute abomination. We had the situation quite recently that 17 hospitals got into that state. We do not know at any point in time how many other hospitals will do so. We have lost 7,000 nurses over the last number of years, so it is clearly an issue. This needs attention and it needs it soon.

There are stories—I have had them as an MP and others get them, and there is a lot on social media about it—and we are not tackling this. Until we accept that this is an important thing and it must be dealt with, my suggestion is actually not just to look at failing hospitals—the 17 and the ones with the high mortality rates—but to look at what safe hospitals do. What do the best hospitals do? Why can we not find what the best, safest hospitals do, and adopt that?

Liz Redfern: That is absolutely part of the picture and goes on too, and you are right, that those needs—

Q272 Barbara Keeley: Why can't we do that?

Liz Redfern: We are doing it in some instances. It is not as widespread as it might be, and we have to encourage trusts, clinicians and teams to learn from each other.

Q273 Barbara Keeley: Sir Bruce is looking at this now. You are looking at failing hospitals or hospitals with poor mortality rates. Why are you not looking at safe hospitals and finding what they do in terms of patient ratios?

Professor Sir Bruce Keogh: We have to start somewhere; that is the first point. Would you like me to get on to the subject of the review that I am conducting?

Q274 Barbara Keeley: No, it is just the patient ratios, because we keep coming back to it and I have to say that, whoever we ask—whether it is senior leaders in nursing or others—we never get an acceptable answer. I have never had an acceptable answer on this and it is very concerning.

Sir David Nicholson: Perhaps I will give you another unacceptable answer. In a sense, where in the world have people decided nationally from a Government Department to set nurse staffing levels—

Q275 Barbara Keeley: I am not suggesting that for a minute.

Sir David Nicholson: Where they have, it has failed very quickly.

Barbara Keeley: I am not suggesting that. I am suggesting looking at hospitals where it works, where there is good safety, and suggesting that that is adopted elsewhere. But clearly there is a denial about this; there is a denial in nurse leadership—yes, there is. We have asked this question here in this Committee—my colleague agrees with me—and we just get back bland answers, and we are getting another set of bland answers today. This is not being looked at, but it should be looked at and it has to be looked at.

Q276 Chair: Let me ask the question. Are nurse staffing levels being looked at, what is being found and what is being done about it?

Sir David Nicholson: This is a really important point, not least of all because, as we go through the next two or three years and the financial position gets tighter, we need to ensure that the staffing levels on wards are safe—and better than that.

There is a whole series of ways you can do that. As I say, some Governments in the past have said, “We will have a national way of doing it.” Generally speaking, they fall apart relatively quickly. Our approach to it is this. There are a number of tools that you can use as a chief nurse of a hospital that help you define what the right staffing level is. Any of these tools on their own will not do it because you need the engagement of the staff in the wards to enable you to do it.

What we are doing at the moment—what we plan to do—is to accredit the staffing-level tools so that we can say, “These are the ones that you should use,” and I think we have already got to a point where we are doing that.

Liz Redfern: We have.

Sir David Nicholson: Then every single hospital has to go through a process where they identify, ward by ward, what their staffing levels should be and they should publish it. In my view, as you come in the

ward, it should show what the staffing level on that ward should be and what it is.

Q277 Barbara Keeley: Will that be required?

Sir David Nicholson: I do not have the power to require it, but it seems to me that is the general approach that we should—

Q278 Chair: You have the power to suggest to commissioners that this is what they should require as part of their commissioning process.

Sir David Nicholson: Yes, absolutely, and that is what I think we should do. I cannot force them to do it, but it seems to be good practice for them to do it. In that transparent way, if you are a patient or a member of staff on that ward, you can look, and you can make the assessment as to how well that is being dealt with. That is where we want to get to.

Liz Redfern: Absolutely. Those are the sorts of conversations I am personally having with the directors of nursing across the south of England—those sorts of issues about how we learn from each other. The other thing to say is that, since Mid Staffs, the original report and all the work that has been put in place around quality monitoring since then, on a very regular basis I, as the chief nurse for the south of England, for example, am looking at a whole range of indicators all of the time.

One of those is nurse-patient ratios, along with numbers of infections, how many people are falling, how many people have bladder infections and how many people have pressure sores. All of those are looked at regularly in order to try and predict where organisations may be going off the types of standards that we would expect. That is the system that is now in place that was not in place at Mid Staffs.

Q279 Barbara Keeley: Was it in place when the 17 that the CQC reported on slipped into having unsafe levels of care? How did that happen? If you were doing what you are doing—I do not know how long you have been doing that—why did we end up with a number of hospitals, and not one or two?

Liz Redfern: It is because of the limitations of looking at something from a distance versus the limitations of the responsibility of the trust board locally. I am able to look at nurse-patient ratios for a trust as a measure. That does not tell me how many nurses there are on any particular ward at any one time because that is the responsibility of the trust board. In that sense, those CQC cases were individual wards, individual services. It was not about the whole trust having a problem. That is the difference.

Q280 Barbara Keeley: But who wants to go into a hospital with the knowledge that there are unsafe levels of care on any of its wards? Frankly, you would not want to go near them.

Liz Redfern: No, absolutely not, which is why the local trust needs to be looking at that all of the time and to be on a day-to-day basis deploying staff in such a way.

Q281 Barbara Keeley: But they are not, are they?

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Liz Redfern: In some instances they are not, and that is not right, and in some instances they are and have very sensitive systems—electronic and human systems—that track this and make those arrangements. You are absolutely right to say that we need to have everybody doing that.

Q282 Mr Sharma: What is happening to those who are not looking at it at this point?

Liz Redfern: I have made it clear professionally, as Jane Cummings, the chief nurse, has, that we would expect every director of nursing on a trust board to have a mechanism for doing this. They are both professionally accountable through their registration as well as personally responsible for delivering that huge investment that their trust gets in the right way for the quality of patient care through their nurse-staffing arrangements.

We expect them all to have a way of doing that. We expect them all to use one of the tools that Sir David has already mentioned. If they are not, then I would expect their trust board to hold them to account for that.

Q283 David Tredinnick: Can I go back to the levels of staffing in wards? It does seem to be incredibly simple for you to put out a circular saying, “We expect these levels to be maintained, and we want each and every one of you to report back via the structures about the levels of staffing in your hospital and the wards.” I cannot see that this is a complicated issue. It seems to be incredibly straightforward. If there is a variation of the numbers in the wards, then there should be a variation in the staff, and it is a very simple ratio issue, isn’t it?

Liz Redfern: Not necessarily, I am afraid.

Q284 David Tredinnick: Can you explain why not?

Liz Redfern: I say that based on my experience of running wards, hospitals and being a nurse. On the actual ward on a day-to-day basis, depending on the dependency of the patients and so on, it is never one thing. It is never just like that day after day. That is where you need to have people who are in charge of those wards, in charge of those hospitals, who help people intelligently to know what they need.

Also, if I could just say, of course the delivery of care on a ward—we are focusing on wards, but, of course, a lot of care goes on in the community—is not just about nursing. It is about the whole team—who else is there to support, to absolutely ensure nurses can do what they are paid and qualified to do and are not changing light bulbs or filling out bits of paper that they do not need to do. So it is about a whole team.

Again, just making some demand for a particular number of nurses takes no account of the other key employees—staff—in that ward who make huge contributions to the care of patients on a day-to-day basis. It is not as simple as that, I am afraid.

Q285 Andrew George: As to paediatric wards, where there is a—

Liz Redfern: There are intensive care units—

Andrew George:—mandated staffing level, you are suggesting on the basis of your answer that that is in fact wrong—in fact, clinically ill-advised.

Liz Redfern: No. What I am saying is that they use that, but, of course, that does not restrict them making those day-to-day changes. So in that sense, it is a guideline.

Q286 Andrew George: Would you not agree that having a guideline that it should never fall below this level at least gives everyone confidence? After you have used the tools to review the situation you can enhance levels beyond that baseline, just as you do on paediatric wards?

Sir David Nicholson: The evidence around the world for this is that that very quickly becomes the norm. No matter how you define the minimum, it suddenly becomes the norm. That is the danger.

Q287 Andrew George: It fails in Australia, does it?

Liz Redfern: There is some evidence emerging from Australia, which is fairly new. We need to keep an open mind on the evidence—of course. At the moment, I do not think there is sufficient evidence.

Q288 Chair: One of the immediate learning experiences of the whole Mid Staffordshire scandal—going right back to what Sir David said about what he found when he first took charge of the Shropshire and Staffordshire Strategic Health Authority—is surely that there needs to be open accountability around this issue of nurse and general staffing levels in care delivery, both inside and outside hospital. If commissioners are going to be part of the discussion about staffing levels, are providers then going to be accountable in public to the commissioners for the delivery of the staffing levels defined by the commissioner?

Liz Redfern: I can make a general point on that, which is that it is really important that, again, we do not lose the bigger picture here about the quality of care that the patients receive, of which staffing levels is a part. The commissioners certainly need to be concerned with a whole range of things through their commissioning conversations and through the plans that the trusts submit in response to those, of which staffing levels is a part. The overall aim of the commissioners is to get a quality of care that is safe, has good outcomes and a good experience. It is always a balance of all of those things.

Chair: I agree.

Liz Redfern: That is, in a sense, a thing that is embedded in the agreement.

Q289 Chair: But if what we are looking for—going right back to the beginning—is a culture change, then staffing levels, although of course not the whole of the quality of care experienced, are an important element in it.

Liz Redfern: Sure.

Q290 Chair: Sir David used the concept that things have to be, first, measurable and, secondly, accountable in public. The reason why I am picking it

up is that it seems to me quite a good illustration of precisely the culture change that we need to deliver.

Sir David Nicholson: There is a slight danger—but only a slight danger—that commissioners will end up trying to run the hospitals, which is not what we are trying to do here. But I think it is perfectly legitimate for an agreement between providers and commissioners to be made, which sets out what the minimum staffing levels are across the wards and that that should be reported on in a public and open way as part of these arrangements. That is perfectly reasonable.

Q291 Dr Wollaston: Can I take you back to the important point you made about hitting the target and missing the point? Was that your phrase, Sir David?

Sir David Nicholson: Yes. Well, I think I made it. In 2006, when I got the job, it was one of the things I—

Q292 Chair: You will hear from whoever the author was if it was not you.

Sir David Nicholson: I know; that is always the problem. Somebody may say, “I said that.” The other thing I said a lot was that organisations should look out to their communities and patients and not up to the centre.

Q293 Dr Wollaston: I quote from the report “Achieving the vision”: “Because of the fear of what will happen if targets are not hit, it’s not uncommon for managers and clinicians to hit the target and miss the point.” That was taken from this report that interviewed 58 individuals. Were you one of those 58 individuals?

Sir David Nicholson: I was not, but I do go on about it quite a lot to my colleagues, so it may be that one of the people were interviewed.

Q294 Dr Wollaston: Yes, so they probably have picked it up, but they were also sharing that concern.

Sir David Nicholson: It is always a danger when you have targets. Targets in themselves are not bad. They can be really positive. If you think about healthcare-associated infection, all of those things have really powerful targets, which have broad understanding, clinical buy-in and you make it, although that one did not always have clinical buy-in, interestingly enough, but that is an example of that. It is the way you do it; it is the way you implement it. That relates to the culture, to the way people operate and to what the values of that organisation are.

Q295 Dr Wollaston: Do you think we have rather let Ministers off the hook here? You referred earlier to being held to account for a whole set of things from the centre—things that you felt were not relevant to the patient and not losing sight of the patient. Are you able to say which Ministers were pushing you to achieve these targets and, say, hit targets and miss the point, which went to the core of what went wrong?

Sir David Nicholson: I don’t think any Ministers would say to me, “Hit the target and miss the point”. That is not what we are saying here—

Q296 Dr Wollaston: No, but being responsible for that culture of top-down targets.

Sir David Nicholson: Fundamentally, if you think about the NHS plan and what happened at that time, the general approach was that the NHS was really rather good; quality of care was rather good. The problem was getting into the system. It was access. That was the focus of attention. In a sense, when we got to the point where we were resolving a whole load of the access problems, the issue about the quality of care became the issue. I do not know whether Bruce wants to say something about this.

Professor Sir Bruce Keogh: I am going to tell it from my perspective, and I suspect Dr Wollaston will see it in a similar way. If I go back to the early 2000s—as some of you know, I am a heart surgeon by background—I would sit in my clinic and two people would come in, usually a man and his wife. We would go through a long consultation on the relative merits and complications of a heart operation and a lot of hard-nosed facts. I would say to the man, who generally needed the operation, “Do you have any questions?”, and he would say no. I would turn to his wife and say, “Do you have any questions?”, and she would say, “Just one.” I always knew what it was. She would say, “When?”, and I would say 18 months to two years, and this look of abject terror would descend over her face, her eyes would cloud over with tears and she would say, “We have waited a year to see the cardiologist and three months to see you. When is this nightmare going to stop?”

In a sense, I protected myself by hiding in the knowledge that the technocratic results of the surgery were as good as you would get anywhere in the world, and yet I increasingly began to realise—and that is one of the things that has driven me into this job—that we were offering a service that was technocratically good but was not good for the patient. It is terrifying, and I am sure the GPs had to pick up the fall-out from some of those conversations.

Then we went through a really difficult time of targets. I call it the waiting-list target. The term “access” is a little remote to me. So we had people waiting on waiting lists, worried whether they would die, and there was some really tough management to make that change. I was leading during that time two different heart surgery units, but one which had the longest waiting list in the country. We had patients on drips waiting for urgent operations, sometimes 20 at a time, and we had burgeoning elective waiting lists. This created a very significant tension. It was with a good relationship between effective managers and clinicians, who kind of aligned to say, “We are going to deal with this problem,” that we dealt with it.

By the time I was director of surgery at the Heart Hospital in 2007, which was a different unit, I would have a similar encounter with patients in the clinic and I would turn to the wife and say, “Any questions?” She would say, “When?”, and I would say, “What about next Thursday or Friday?”, or something. Again, a look of abject terror would descend because people did not realise that things could happen quite so quickly. That really changed the dynamic between the clinicians, who are trying to deliver a service, and those who receive it. Now they

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are no longer just frightened about whether they are going to get treated. The whole conversation has now shifted to quality.

The timing of all of that was quite interesting in the sense that it related also to the time that Ara Darzi came in as one of the Ministers and went through the process of developing “High quality care for all”, developing a definition of quality. That has enabled us to think about how we are going to drive quality forward in the NHS. The definition of quality was really quite an important step forward.

We are the only healthcare system in the world—and thank you, colleagues, in this room for getting it into legislation—that says that there are three domains of quality. One is effectiveness, and we have not been too bad at that in terms of the technocratic results of our interventions. We are ahead of the rest of the world in some aspects of safety, but we still have a long way to go. Frankly, when we have been looked at by independent observers such as the Commonwealth Fund, a think-tank in the United States, we do well. In most areas, they rank us generally number 2 of the seven big systems that they look at.

But we always fall down on timeliness, which is what I would call waiting lists, and, secondly, on personalisation. Personalisation means treating people who come into our service with the same level of courtesy that we would treat visitors into our own home and affording them appropriate respect, and, in commercial terms, providing a decent customer service. We have fallen down, in my view, badly on that. That has really come to light through events in Mid Staffs. That epitomises the problems that come out of that lack of focus.

When I look at the current reforms that have just gone through, putting aside all the structural issues, it seems to me that there are three main things that underpin those. The first is to make clinical outcomes the currency of the NHS. Patients get clinical outcomes; they want to get better. Clinicians get them; they want to get better. Now we have a situation where those clinical outcomes are the common goal of the managerial community, the professional healthcare community in the NHS and patients. So, in my mind, if we get this right, we have a set of common goals, which did not necessarily exist when there were tough battles around dealing with waiting-time targets and so on and so forth.

The second thing is the promotion of clinical leadership, which Ara Darzi started, and is now, I guess, best articulated by the clinical commissioning groups, a clinically-led and driven new commissioning board and a lot of clinical leaders associated with that. But I would like to say there is very clear evidence that in hospitals, where you have a high level of medical engagement, that translates into better clinical outcomes at every level from mortality downwards. So we need to promote that.

Again, as to the engagement of the clinicians in Mid Staffordshire—and I have said this to the Committee before—there was a failure of leadership and there was a failure of professionalism. To put that quite bluntly, when there are difficulties in a hospital—and I have had arguments with my own colleagues from time to time—if 10 consultants show up in a chief

executive’s room and say “There is a real problem here,” you know which way that conversation is going to go. That never happened in Mid Staffordshire. There are issues about professionalism and medical leadership that we need to get to the heart of, and I have alluded to personalisation.

May I just, Chair, if you will forgive me, outline some of the processes that we are going to use to try and get to better quality? This is not in the wake of Mid Staffs, but this was really from Ara’s review, which was driven by David. We have a definition of quality. I am a firm believer, as you know, in the measurement and analysis of quality, and we are going to measure quality in all of those three domains. Hence we have a bunch of measurements for clinical effectiveness, a new series of measures for safety, and we are thinking through some good and concise measures on patient experience. We will publish those.

Indeed, in the time since I have been medical director and David has been chief executive of the NHS, we have published over 600 measures of performance on NHS Choices. Some of them, to be honest, are a little bit difficult to get to. We are focusing on how we reward people for improving quality. A good example would be fractured neck of femur. Over the last decade there has been a 25% reduction in death from fractured neck of femur, which is a terrible condition for elderly people who fall over, and in the last couple of years we have reduced it quite a bit further. We have done that by linking quality measures into payment for that condition.

The safeguarding of quality is an issue largely for the regulators. In terms of promoting quality, we are doing much of that through the newly announced and designed academic health science networks, which we believe will be significant agents for change. One of the things that is quite clear when you visit the academic centres in the United States, for example, is that, where the academic centres work in partnership with not just their local teaching hospitals but the equivalent of district general hospitals, you get a feeling of engagement that did not exist before, and that promotes innovation because many of the solutions to our problems do not lie in people sitting in darkened offices. They lie in the intellectual capacity of those who work at the front line in the system. In our case, that is a big intellectual reserve of 1.4 million people.

So we have, in my view, by using the academic health science networks as our drivers for change, the opportunity to innovate in a way that the NHS has not. I believe that innovation is one of our other missing ingredients, apart from the focus on patients. If we can get the innovation right, that takes us into a tipping point for our NHS because it will bring the newest treatments, be good for patients, exciting for clinicians and good for UK plc. Underlining all this, our focus has to be on leadership, and David might want to say something about the Leadership Academy and the focus that we are bringing.

The other thing that worries me a little bit on leadership is this. I have been on the Council of the Royal College of Surgeons on two occasions, and I have watched the leadership organisations of various clinical tribes, if you like, and interest groups slowly

feeling that they have been relegated to the position of commentators rather than participants. We have moves in place now to try and bring those organisations back into the mainstream delivery of the NHS, which is where, frankly, they would like to be. They do not want to feel excluded. I am sorry—this has been a long answer.

Chair: You have sat in respectful silence for quite a long period and I was looking for a way to bring you in, but you found it for yourself. Thank you very much.

Q297 Dr Wollaston: Can you clarify something? You talked about the three main points for the future and you talked about the clinical outcomes being the currency promotion of clinical leadership, but was your third point about personalisation or did we not get to the third point?

Professor Sir Bruce Keogh: I was trying to shorten my answer.

Q298 Dr Wollaston: Was that the third thing?

Professor Sir Bruce Keogh: Personalisation, in my view, is two things. We hear a lot—

Q299 Dr Wollaston: Was that the third thing?

Professor Sir Bruce Keogh: Yes. We hear a lot of rhetoric about personalisation, but personalisation is a spectrum. On the one hand, it is affording people, as I have said, the simple courtesies that you afford somebody who comes into your own home.

If somebody comes into a clinic, it is standing up, shaking their hands, opening the door, that sort of thing. That is just basic. At the other end of the spectrum, there is the sort of hard-core pharmacogenetics. There is a big opportunity for our NHS to try and get much more focused and targeted treatments.

As you well know, people come in and out of your clinic, you have to try different tablets and eventually you find something that works. But we are getting to a point now scientifically where we can start on, I guess, relating your genetic construct to how well you will benefit from different types of treatment. We have a unique opportunity in this NHS to take advantage of that. We probably lead the world in some of the intellectual capital around this, and we are currently working on how we can start to bring that to our patients.

Chair: The whole question of the implication of genetics is a subject probably for another day. A number of my colleagues want to get in.

Q300 Valerie Vaz: I just want to pick you up on a point that you made. Did you say that, because the 10 consultants did not go into the boardroom, that is what the failure was at Stafford hospital?

Professor Sir Bruce Keogh: No. I think that was a metaphor.

Q301 Valerie Vaz: What did you say exactly?

Professor Sir Bruce Keogh: I think that is oversimplifying it.

Q302 Valerie Vaz: What did you say then?

Professor Sir Bruce Keogh: The message that I was trying to get across was that when consultants really want something to happen in their hospital and really want to improve something, if enough of them want it and enough of them sit down and engage with their managerial colleagues, it will happen.

Q303 Valerie Vaz: That is the key point, isn't it—“engage with the managerial colleagues”. But the person who appointed you, sitting next to you, has said that he thought that there were no clinicians present at the board and yet he did not do anything about it. So I don't think you can just blame the consultants for not turning up in the boardroom.

Professor Sir Bruce Keogh: I did not say the boardroom, actually.

Q304 Valerie Vaz: Get cross if you like, Sir David, but I just have a question for you, and this refers back to Mid Staffordshire and Stafford hospital. What do you see as the role of the directors of public health, and did they ever come to you during your time there and say, “We have concerns about the mortality rate”?

Sir David Nicholson: Honestly, I am not getting cross about all of this.

Q305 Valerie Vaz: Just answer the question. Forget about it; I don't mind if you get cross. I just want you to answer the question.

Sir David Nicholson: But you made an aside, a comment there, didn't you? I didn't do nothing about it.

Q306 Valerie Vaz: It was in your evidence.

Sir David Nicholson: I set out to the chairman and chief executive what my expectations were about them recruiting a medical director and getting clinicians engaged in their service. That is what I did. I didn't do nothing.

Q307 Valerie Vaz: That never happened, and part of all our jobs is to follow up on what happens. Lawyers do it all day long. You have to follow up what goes on. Doctors do it; everyone does it.

Sir David Nicholson: And I did follow up.

Q308 Valerie Vaz: You didn't.

Sir David Nicholson: I did follow up.

Q309 Valerie Vaz: You didn't. Well, your evidence does not say you did.

Sir David Nicholson: I did.

Q310 Valerie Vaz: Can I just go back to my main point? Did a director of public health, or anyone from public health, ever come to you and say they had concerns about the mortality rate?

Sir David Nicholson: No.

Q311 Valerie Vaz: Not at all?

Sir David Nicholson: No.

Q312 Valerie Vaz: Sir Bruce talked about managers. Is there a managers' code of conduct that says—

Sir David Nicholson: Yes.

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Q313 Valerie Vaz: What does it say about putting patients first?

Sir David Nicholson: It says you should put patients first.

Q314 Valerie Vaz: Right. Do you think that happened there?

Sir David Nicholson: No.

Q315 Valerie Vaz: So what are you going to do about that now in line with the Francis recommendations?

Sir David Nicholson: I think we are going to respond to the issue about codes of conduct, manager regulation and accountability in management as part of the Government's response. We have not finalised that. As I say, Ministers are still considering it, but that needs to be a part of our response.

Q316 Valerie Vaz: But you wanted to do that about the duty of candour. You have already done that in terms of the duty of candour—

Sir David Nicholson: We have put that in.

Q317 Valerie Vaz: Can I just finish what I am saying?

Sir David Nicholson: Sorry.

Valerie Vaz: You have done that in relation to the duty of candour and the Francis recommendations. You are choosing to do some, but not others. Is that right?

Sir David Nicholson: The thing about the duty of candour is that we are drawing up the contracts for 2013–14 at the moment. If we didn't take the opportunity to do it now, we would not have the opportunity until 2014–15. In those circumstances, it seems to me that swift action is the right thing to do. We are taking a little bit more time because we do not have that timetable of discipline on us in relation to the second one. So we will take our time.

Valerie Vaz: Thank you.

Q318 Andrew George: Sir Bruce, in your description of this new world that we are moving into, you used a lot of conceptual management jargon, if you do not mind me using that expression, in terms of the hundreds of guidelines and measures and so on that will be put in place to address a lot of the failings in the system that you and, indeed, a lot of people have identified.

The Francis report has identified systematic failings. I recollect the period in 2004–2005 when a lot of systems were being changed and there was a lot of warm conceptual jargon used then to describe a lot of the management changes at that stage. If the system that you have described—and Sir David is clearly supporting—likewise fails, who will be held accountable?

Professor Sir Bruce Keogh: First of all, I have never been accused of speaking management jargon before, so I am not quite sure whether that means my conversion is complete.

Let me be quite clear. If I have given that impression, it is wrong. When I talk about measurement, I talk about clinical measurement. I believe—and I have a

fundamental adherence to this—that anybody involved in healthcare should be able to describe what they do and define how well they do it. That applies to individuals and to organisations. I have used that in my own practice and I have used it to help develop heart surgery in this country.

Everything is around that principle. If you know what you are doing and how well you are doing it, and if you know that within the three domains of quality I have alluded to, then you will know where to improve. If you think that our hospitals are simply aggregates of different clinical services and those clinical services themselves are aggregates of different clinicians, the first line of defence in quality and the first line of accountability lies with the clinician in that private and trusted relationship with their patients. The next level of protection and accountability for quality lies with the trust board, and David Nicholson has clearly outlined the accountability there. The third level lies with the regulators.

But I think we need to get to a point where people recognise that the first building block of quality is around professionalism in that encounter between someone who feels unwell, frightened and scared and needs help and the person that is offering that help. That is the first level of accountability.

Q319 Andrew George: The lines of accountability are at clinical level, trust board level and then with the regulators. The people who designed the system are not accountable.

Professor Sir Bruce Keogh: Of course the people who designed the system are accountable.

Q320 Andrew George: In what way? You have just described three tiers of accountability, but with Mid Staffordshire you had systematic failure. That was a systems failure. Who designed the system? Who created the system? Who analysed that system?

Professor Sir Bruce Keogh: I have no idea who designed that system. In terms of measurement, although you might think that is management speak, I go back to my point about everybody knowing what they do and being able to define how well they do it. I think we need to get to a point—and I promoted this well before I was ever appointed NHS medical director, both nationally and internationally—where each and every service line should measure, analyse and publish its results.

If I go back to my own specialty, we went through, in North America, in parts of Europe and particularly in this country, some difficult issues about how to analyse the results of heart surgery. You may think that is relatively easy and sort of binary, but it is more complex than that. We went through a process of working out how to publish those results in a way that did not unfairly penalise surgeons who took on high-risk cases, because the net result of that would be high-risk avoidance, and we went through a process of working with patients as to how to publish this data in a way that was clear and meaningful to them and also to cardiologists and others who referred patients. I believe that, ultimately, that is what every trust should be doing.

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We have embarked on that journey and been on it for some time. We expect that in the quality accounts that we expect trusts to publish on an annual basis, and you will see that, as part of the NHS planning guidance for a number of specialties, we have now embarked on publishing this sort of data down at individual clinician level.

Q321 Barbara Keeley: I have to say I think you are slipping into the management jargon.

Professor Sir Bruce Keogh: Am I?

Q322 Barbara Keeley: You started your career as a surgeon and we have found that nurse leaders are just the same. Frankly, it does not help. I have to acknowledge that I started my career in the IT sector, so, across many years, I was used to jargon, but it is better not used as much.

As an MP, I have had a case of appalling NHS treatment of a constituent. It amounted to neglect and was a really bad case. The details, in many ways, were similar to the patients' stories at Mid Staffs. I know that that family felt hurt, let down and angry—very angry—with the NHS, and probably always will. What we have coming out of the Francis report and the Mid Staffs situation is hundreds, if not more than a thousand; I do not know how many families there are. I want to ask you—Sir David, more than anybody else—what you say to those hundreds of people in

Mid Staffs who lost a loved one and whose memory of that loss is now stained by things like seeing them lying in soiled sheets, by falls, things that were avoidable, and by the complete neglect that I have seen in a constituent's family, but here we have it echoed by hundreds, if not thousands? What do you say to those people?

Sir David Nicholson: All I can say in the circumstances that they find themselves in is that I acknowledge their grief and the hurt that they must feel and apologise on behalf of the NHS and myself for what they have happened to see.

As to whether there are things we can do to help them as individuals, one of the things we offered in Mid Staffordshire was a sit-down with a clinician and the case notes, to go through in detail what happened to their loved one so that we can all understand better what happened and what implications there were for the length of their life or their last few hours on earth. With all of those, we can do that, and we can make sure to do everything in our power to ensure that it does not happen again. One of the things about the Francis report, and indeed the action that we have taken since 2009, is designed with that in mind.

Chair: On that note, I am going to draw the session to a close. Thank you for coming.

Tuesday 19 March 2013

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper
Andrew George
Barbara Keeley
Andrew Percy

Mr Virendra Sharma
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: **Gary Walker**, former Chief Executive of the United Lincolnshire Hospitals NHS Trust, and **David Bowles**, former Chair of the United Lincolnshire Hospitals NHS Trust, gave evidence.

Q323 Chair: Good morning. Thank you for coming to join us this morning, both Mr Walker and Mr Bowles. You are extremely welcome.

I would like, if I may, to say a few words by way of introduction to this session, because it is very important to be clear as to the scope of our interest. The session takes place in the context of our review of the Francis inquiry and its implications for the future of the NHS—in particular, the recommendations that Francis makes about the need for a culture change in the health service to make the service more open and to ensure that those with concerns about the safety and quality of care being delivered within the system feel able, empowered and encouraged to raise concerns where appropriate. It is that aspect of the story of what happened in Lincoln that is of prime interest to us.

We clearly are going to refer to events that happened in Lincoln, but we have no power and do not have the means to make findings of fact. We simply want to hear your evidence from your point of view about the extent to which there was a healthy culture in Lincolnshire and your relationships with the rest of the health service, and, to the extent that there was not a healthy culture, what lessons that has to teach us about steps we need to take to encourage a more healthy culture in future. That is the scope of our interest. If I may put it simply, we are not an employment tribunal and we do not intend to be drawn into debates about what happened in terms of determinations of fact. It is issues of policy that are of concern to us.

Against the background of the correspondence between the Committee and Mr Walker in particular, and to a lesser extent Mr Bowles as well, I want to give you the assurance that this hearing is governed by parliamentary privilege. It is a parliamentary Committee, and therefore anything that is said here is fully privileged in the legal sense. It is also, of course, public. This is a public forum. As to evidence presented to a Select Committee, our invariable practice has been to publish it because we think it is inconceivable, frankly, that evidence presented to and, in particular, evidence referred to in a public session should be regarded as in any sense private. So it is privileged, but it is public. We need to be clear that those are the ground rules on which the hearing proceeds. Do you want to react in any way to anything that I have said so far?

Gary Walker: No.

David Bowles: That has been very helpful; thank you.

Q324 Chair: Starting with Mr Walker, can you talk the Committee through your view of your experience as chief executive in Lincoln? What were the instances that you would wish to draw to the Committee's attention that illustrate the failure of culture that you clearly believe existed in Lincoln?

Gary Walker: Thank you. I am sure we will get into more detail, but I will give a brief overview of it. I went to Lincolnshire in 2006 largely because it was a failing organisation that was in a turnaround situation. It had a very bad Healthcare Commission report at the time. That report spoke of a culture of fear, that waiting lists had been fiddled, there were problems in the organisation and it was in extensive debt, overspending by about £1.2 million a month. For the first two years, a new board was put in, with me, David Bowles as chairman, and, essentially, an entirely new executive and non-executive team over the next six months after I arrived.

Then we set about turning the organisation round, paying off pretty much all of the debts within the first two years and achieving five-year break-evens from the finance point of view. We also achieved consistent year-on-year performance improvement in Healthcare Commission ratings at the time. We halved waiting times and nearly halved hospital-acquired infection levels to some of the lowest in the country.

All of that was going quite well. Then, in 2008, the decision was taken to extend my contract again for two more years. Because I was a turnaround chief exec, those contracts tend to be more fixed term or flexible contracts rather than permanent. The health authority approved my extension of contract for another two years in the middle of 2008. We were also asking at that stage for provisions of things such as what we call a capacity review, because the contract that we had with the PCT was over-performing.

As to events that perhaps started around then—and I will give you the first example—we went on something called red alert. Red alert is a normal procedure that all hospitals in the country go on when they are full up. Triggers like ambulances waiting outside would set you on to red alert. The response from the health system would be that GPs and other hospitals would take a plan that they have, which might be calling in more staff or putting on more resources, and ambulances might be diverted to other hospitals—that sort of thing. I got a phone call from

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the health authority saying, “You are on red alert. It has caused us”—

Q325 Chair: That is from the health authority.

Gary Walker: From the health authority.

Q326 Chair: From whom?

Gary Walker: That was from a person called Dale Bywater.

Q327 Chair: When you say the health authority, do you mean the PCT or the SHA?

Gary Walker: Yes. I mean the East Midlands Strategic Health Authority. It is a long name, so, if I say “health authority” from now on, it is that. I had a phone call from him saying that, by going on red alert, I had embarrassed the health authority in the eyes of Ben Bradshaw, who was then Minister of Health, that this caused a significant problem, Barbara Hakin had been informed and that I would get into some kind of trouble as a result of this. I could not understand that response because, quite frankly, it is a normal thing. In evidence to the employment tribunal that we will not go over, Dale Bywater and Barbara Hakin conflict on what was said at that point, where I think Barbara Hakin said red alerts are normal and Dale Bywater said red alerts were an inconvenience. That was essentially the situation.

Immediately after that, I got a phone call from Barbara Hakin saying, “We are about to approve £11 million-worth of funding for your trust and that is going to be very difficult while you are on red alert. I am about to go to my board this morning and ask for approval, but you are on red alert. So how can I do that?” I do not personally see the link between £11 million-worth of largely capital funding to build facilities and being on red alert. I think the two are completely separate. One is about operationally running a hospital safely and the other is about longer-term plans. That would be the first problem.

Then, towards the end of 2008, other events were occurring where we as a trust were saying, “We are very concerned that the organisation is going to miss the targets because the hospital is getting very full of patients. We are over-performing in all the lines of the contract by 10%, and it is probably going to be quite difficult to achieve the targets.” We informed the health authority of this in December 2008, and there was no real response at that stage.

The response did not come until the new year, with the health authority then saying, “You really need to hit the targets. You need to hit the targets.” We were saying, “There is nothing happening here in this system. We are continuing to see more and more patients, and we are going to have to start cancelling patients in order to run safe hospitals.” Over the next few weeks we cancelled 700 or more operations—it may have been over 1,000 in that quarter—but most of those happened in the January or February time.

Then I was asked to see Barbara Hakin. I met Barbara in February 2009. Essentially, as you have seen from my statement, certain threats were made to me in the sense of, “If you do not deliver the targets, then I will not be able to protect you.” I would need to refer to my statement about exactly what the words were

because it is quite some time back, but, in essence, there was clearly a lot of pressure to deliver the targets and this was going to reflect on me as an individual if we did not deliver the targets. But, of course, at the same time I was asking for a capacity review, asking for help, and this sort of situation escalated as we went through this.

As the hospitals became more and more full, more and more threats were made. I will give you one example of that, which I think is quite important, from around February 2009. This was actually a period when I was not at the trust on this particular day—18 February. Barbara Hakin spoke to the director of operations at the trust. The reason I am bringing it up now is that Barbara has agreed in her witness statement that this is a true account. In the note of that meeting that Barbara Hakin has seen, she is reported to have said to my director of operations, “If you can’t manage an A and E”—which is referring to hitting the target—“you can’t run a hospital.” In the context of the culture of the NHS, where you cannot speak out without fear of actions being taken toward you, you certainly cannot fail to hit the targets without threats being made to you. This was interpreted as a threat, and Barbara Hakin has agreed in her evidence that was about to go in front of a public hearing that that was true. I find that to be pretty black and white evidence of a threat—the similar sort of threats that were being made to me. I am conscious you want to interrupt there, but there are many more as the months go on.

Q328 Chair: What I am trying to do is interrupt you to summarise the story so far, as being that you were introduced into a turnaround situation, and until the summer of 2008, you felt all the relationships were open and healthy.

Gary Walker: I had not had much contact with the health authority. They tend not to speak to you. I had started in October 2006, and probably for the first few Mondays for maybe a period of three or four months, perhaps once a month, I would have a telephone call with Barbara Hakin. But, after that, I may have seen the health authority staff three or four times in a year.

Q329 Chair: This was through to June 2008.

Gary Walker: Yes.

Q330 Chair: Until that time, there was relatively little contact.

Gary Walker: Yes. I was going to chief exec meetings probably, as I say, four to maybe five times a year.

Q331 Chair: It was from that point that you began to feel yourself subject to threats, first around the £11 million and then later around the—

Gary Walker: To be honest, the £11 million and the red alert situation I put down as a one-off. I did not believe at the time that that was a threat. I only believe that now in hindsight looking at what happened over December 2008 through to July 2009.

Q332 Valerie Vaz: I have two tiny questions, to take you back to the beginning. Did you apply for a post that was advertised or were you asked to apply?

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Gary Walker: I was asked to apply.

Q333 Valerie Vaz: Who asked you to apply?

Gary Walker: Barbara Hakin asked me to apply.

Q334 Dr Wollaston: I have a very quick clarification. Did Barbara Hakin approve the £11 million funding? Was the capital funding approved?

Gary Walker: It was approved. It was a strange approval in the sense that half of it was given in cash and the other half was given in a kind of accounting entry that no one really understands, but, yes, eventually it did get approved, and it was actually the PCT in fact that was asked to find most of that.

Q335 Dr Wollaston: Sorry—you did not understand what the accounting arrangement was.

Gary Walker: [Interruption] It was partly the rent money. Half of it was to do with—well, we were arguing it. It is a complex situation. Back in the 2006 period, there were a lot of strange accounting practices going on around resource accounting and budgeting. The trust, before we got there, had borrowed lots of money and had overspent. We are going to get sidetracked into financial accounts and what they used to call double—

Q336 Dr Wollaston: Did you understand it? Was it clear to you and did you query it?

Gary Walker: I was quite happy with eventually how it was settled. But, in terms of the health authority's approval for it, the health authority paid about £6 million and the primary care trust had to pay £5 million. But, again, it was a technical accounting move—there wasn't really cash behind it. It looked as though £11 million had come in, but it was in fact £6 million.

David Bowles: Can I clarify this particular point, Chairman? I do not want to get into the technical detail, but, for whatever reason, the way the accounting system was running is that deficits were effectively doubled for a while because of strange quirks in the accounting system. The Government realised it and decided to put it right. They issued a press release saying, "These are the trusts that are affected. We are going to adjust their accounts by these amounts." ULHT should have been on that schedule and should have received directly from the Government compensation of circa £11 million. We were not on that schedule. When I raised it with my director of finance, I was told we were not on that schedule because, "This trust is not to receive a cash adjustment as the SHA did not wish to identify any trusts in the East Midlands as being financially challenged."

The very clear implication of that is that the financial distress in ULHT was being deliberately concealed from the centre to make the strategic health authority look good. It would be fair to say that I did not react terribly well to this news, because this was my trust that was about to lose £11 million-worth of compensation that every other trust in the country was going to get, and the reason we were going to lose it was because the SHA did not wish to identify any trusts in the East Midlands as being financially

challenged. I raise it because it is a sign of that culture that you were talking about, Chair, of not owning up to problems, not being open and transparent. It is this financial adjustment that Mr Walker was referring to that they were threatening to withhold.

Q337 Dr Wollaston: But you did receive the money, albeit in a sort of odd vehicle, which was only understandable to those who manage trusts but wouldn't be able to—

David Bowles: Yes. My concern is that East Midlands somehow somewhere probably lost out on some money. How they found the money within East Midlands, I do not know, but I suspect the East Midlands as a whole probably lost out and we got recompensed—but probably at other people's expense.

Q338 Chair: I take the point that it may be that this was not fully accountable in public through the SHA, but, in terms of the culture in Lincoln, I think you said that you did not really see the debate around the £11 million as particularly threatening to your position as chief executive or, culturally, at the time—

Gary Walker: At the time, that is right.

Q339 Chair: You did not find it a particularly threatening experience.

Gary Walker: No; I would not say I did not find it threatening. I recall at the time, because of notes kept from that period, that I was amazed that anybody would do that, but I assumed it was just a kind of blip; it was perhaps Barbara Hakin on a bad day or something. I could not understand why anybody would ever put that kind of sentence together.

Q340 Chair: The reason I dwell on this—and then I am coming to my colleagues who want to come in—is to observe that you were running a major hospital and these are very large sums of public money that are involved. One of the questions here is where effective engaged management—management that will not always agree and will sometimes have some difficult conversations—falls over from being engaged management dealing with difficult issues into something that is threatening.

Gary Walker: Yes.

Q341 Chair: As I am hearing it, you are not making the case that that was your experience, certainly not until the end of 2008. My further question is as to how that developed in the early part of 2009.

Gary Walker: Indeed. I would not say "threatened" was the right word at that stage. I thought it was inappropriate and unprofessional, but I did not think it was anything that was going to lead to personal attacks, which is what then followed.

Q342 Chair: But then, as you moved into 2009, you were dealing with some operational pressures where you were putting the hospital on red alert, it was not welcome news, and there was a debate between you and the health authority as to what was the proper response to the demand pressure that you were experiencing.

Gary Walker: Yes. If I can pick up from the February period, there was going to be a meeting with the Department of Health, because obviously the Department of Health were quite concerned if we were not going to deliver the targets and wanted to know why we weren't. We prepared a presentation—or, in fact, I prepared the presentation—for the health system, for the primary care trust and for the health authority. Immediately before going on a teleconference with the Department of Health, I was asked to remove any reference to the fact that I had asked for a capacity review for the past six months. The importance of capacity reviews is very simple. The second you ask for one you should get one, and they are triggered at anything over 5% over the contract—a significant performance over the contract. So, in our terms, if I give you a financial value for that, that would be in the sort of order of £10 million to £15 million of care that is over the contract. So I can give you a financial value to it. We had been asking for this for six months because we could see the pressures coming and we were trying to avert them.

There are two things that happen as a result of calling for a capacity review. The first one is that your performance of targets is suspended and you have to report that up the line to the Department of Health. You do not have to report hitting what at that time was the 18-week target, which, as you know, was a very important target at that point. The second thing is that the whole system has to come together to solve the problem. It is not the case that one organisation has to fix it. So a capacity review is very important.

Q343 Chair: When did you first ask for a capacity review?

Gary Walker: It was either May or June 2008.

Q344 Chair: You were asked to take it out of a presentation in 2009.

Gary Walker: It was in February 2009, but obviously this had been going on in various meetings and conversations with others for many months. The response from the health authority was, "This is your problem. You need to meet the demand." The phrase we will come to talk about is, "You need to meet the targets whatever the demand." That was a phrase that Barbara Hakin—and we will go on to it—has said and has put in writing as well. In the context of what I will explain for the hospitals later on in that year, it is a very dangerous thing to be trying to push through targets when hospitals are dangerously over-full.

If I can pick up on February, realising that we were not going to get a capacity review and I am getting told, "You must meet the targets whatever the demand," and there was going to be no joint planning at all, we put plans in place to open up an extra 100 beds. This is quite important because we as a trust could not afford to build these beds, because it was going to cost £7 million or £8 million. In the end, it cost £8 million. But we thought in February 2009 that it was going to cost about £7 million. We needed an extra 100 beds and we said, "When those are built, we will be able to deliver the targets. That is how much more capacity we as an organisation need."

The reason we needed that was because of the over-performance in the contract. The reason there was an over-performance in the contract was not only was there year-on-year increase in demand, but the primary care trusts had tried to buy less year on year because it was their plan to move care into the community. The plans, if you like, were in accordance with the planning regime at the time, which was more about care in the community, but the reality was that none of that happened; it just did not work. That is called demand management. That is what the phrase is.

Q345 Chair: It is not unfamiliar in the health service, is it? There is a cash limit in the health service and choices have to be made about the use of resources. So I can understand, if you were applying for a capacity review, that that brought everyone to the table to have the discussion about how you were going to address the issue. What was your response when they said, "Please do not raise it."?

Gary Walker: At that time—it was done immediately before the presentation to the Department of Health—there was just a lot of uncomfortable silence.

Q346 Chair: But you said it had been under debate for six months.

Gary Walker: Yes. I was obviously not wanting to upset the system at that particular time because—

Q347 Chair: If you knew you were going to be doing a presentation to the Department of Health and it had been under review—

Gary Walker: Well, I had put it in the presentation.

Q348 Chair: And you had been feeling that you were getting close to needing a capacity review for six months, why did you allow yourself to get to within minutes of a presentation without having rolled the pitch—established that you needed a capacity review?

Gary Walker: Actually at that time I did not want to upset the health authority, but, in hindsight, it was not the right thing to do.

[Interruption] That is a reasonable point. The capacity reviews that we were asking for in the summer were on specific areas of the contract. By the time it got to the new year, to 2009, we were now talking about the entire contract, so we were talking about the £300 million-worth of services.

Q349 Chair: I am sorry to pursue the point, but it does seem to be pretty fundamental to your case, because, as we are going to go on to explore, your case was that there was a choice between patient safety and meeting the target, and that choice was necessitated because there was inadequate capacity; yet you tell us that in the summer of 2008 you were already becoming concerned about lack of capacity. Six months later, you wanted to put the case for a capacity review into a presentation to the Department of Health and withdrew it at a few moments' notice.

Gary Walker: Yes.

Q350 Chair: That is the case that—

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Gary Walker: That was at the demand of a senior officer at the health authority. The reason for not pursuing it at that particular time is that I was under the impression that we were in it together, as it were, and we were going to work it out, and, for some reason, they did not want to talk about that to the Department of Health. In hindsight, I agree with you; I would have done that. But then what kind of a situation would we be in if there were three people sitting in on a teleconference arguing over a capacity issue that the health authority did not want?

Q351 Chair: I am seeking to draw the issue out, Mr Walker, not to act as prosecutor. I can understand you might tactically have concluded, "Okay, we will not front this up to the Department today," but, if I had done that, then I would have been on the phone the following day to the health authority saying, "I went your way yesterday. Now we are going to talk about this capacity review."

Gary Walker: The irony of it is that, in the presentation, it was in fact the gentleman on the other line from the Department of Health who asked for a review in the end. That review was, in fact, never carried out by the health authority. The irony is that, although we took it out, it was in fact requested by the DH.

Q352 Dr Wollaston: Why did you not at that point say, "Yes, I agree it is necessary."? If the Department of Health had said to you, "Do you need a capacity review?" did you say, "No, actually, everything is all right," or what was your response when they suggested it to you?

Gary Walker: I think it is important to understand the working relationships of the NHS. If you upset a strategic health authority, particularly the one I was working in, there would be repercussions for you. So you do not upset them. You work in that environment as best you can. I admit that I was unhappy about it, and certainly later on you will see I did raise this as being something I was unhappy to be forced to remove.

Q353 Dr Wollaston: But you were offered the chance. The Department of Health said to you, "We will offer you a capacity review," and you said, "No, we do not need one."

Gary Walker: No, I agreed. On the teleconference, I agreed that one was needed.

Q354 Dr Wollaston: You did; I am sorry. But that did not happen.

Gary Walker: No; that never happened.

Q355 Andrew George: I want to go back to why we have invited you both here, which is the Francis review and the culture within the NHS. This is not an opportunity to re-air a tribunal; it is an opportunity to look at this in the context of what is going on in the NHS in the years leading up to this and, indeed, afterwards. The problem I have is that, from all that you have described, it sounds as if Lincolnshire was operating as an island. You were just talking about a

culture that existed within the East Midlands Strategic Health Authority. So can I ask you this question?

I assume that you talked to your peers about the difficulties that you were experiencing. Presumably, you then spoke to your peers in Nottinghamshire, Derbyshire, Leicestershire and elsewhere to say, "Have you experienced the same problems of this unreasonableness?" If you are making the point that this is not simply a personality clash between you and Barbara Hakin, or something else going on, or that Lincolnshire was not being uniquely picked on, which is the purpose of what we are trying to get to, there must have been a culture going on. To what extent were you picking up the fact that there was a pattern that was in fact being repeated elsewhere?

Gary Walker: I did at the time talk to my peers—other chief executives—and I would say that many of them, but not all, would concur with my view that the view from the health authority is they were only ever interested if you are going to suggest that there is a problem anywhere and they are very heavy-handed about how that problem is resolved. So threats are made and people are told, "Well, you realise the consequences if this or that does not get done." This is not proper management. This is just sheer bullying.

Q356 Andrew George: Was your case unique because you were prepared to stand up to them? Is that the reason?

Gary Walker: It was in fact the stance I took with them. At the time, we were just discussing, I am trying to co-operate and work with them. But, as time goes on, I can see that more risks are coming up in the trust and nothing is going to change with their approach. So I have to stand up to them.

David Bowles: Might I clarify a point about Mr Walker's appointment that I think also relates to your point? When I was appointed as chairman, there was a different regime leading the East Midlands Strategic Health Authority, a different chief executive and regional chairman. My board described to me events in meetings with senior officials at the East Midlands Strategic Health Authority that I found absolutely shocking—thumping the table, berating, the trust being forced to do work for which it was not paid in accordance with the tariffs, so that the deficit in Lincolnshire ended with the trust. They described to me incidents and events that I found outrageous.

I appointed Mr Walker because, in interview, he showed the integrity and backbone to stand up to that sort of intimidation and bullying. Unfortunately, we got into financial and performance difficulties because of over-performance of the contract, but he did what I appointed him to do, which was to act properly throughout, to try to prevent patients coming to risk, to not ram patients through over-full hospitals and stand up to the SHA. There are times when we perhaps duck and dive on those relationships because he has tried to maintain those relationships with the East Midlands Strategic Health Authority, but, at times, as Mr Walker has said, he did not want to have a row with senior people of the East Midlands Strategic Health Authority just before a Department of Health presentation.

Q357 Andrew George: You had spoken to your peers—the chairs of other trusts—and they were experiencing the same pattern of behaviour.

David Bowles: Yes. The quote that is used is, “If you are not on the radar, you are okay.” The minute you are on the radar, you have problems. What I experienced and what other people tell me is not what I would regard as a managerial response. It is not a case of, “We are here to help. Let us actually understand the problem.” If you understand the problem, you have a chance of sorting it. It is more around, “How can we cover up the problem? How can we sack people? How can we just move this on—fix it?”—fix people, not fix the problem. That is a deep-rooted culture, I am afraid. If you read the Mid Staffordshire report, it talks about things like bullying, target-driven priorities, denial, and it goes on and says that this was not only in Mid Staffordshire, but they collected evidence that said it existed elsewhere. I can assure you it existed in this part of the health economy.

Q358 David Tredinnick: For absolute clarity, what you are saying, as I understand it, is that the problems that you faced in terms of your relationship with the Department and the strategic health authority were in fact replicated right the way across the country and that you are not a unique situation: you are one of many. You could probably, I imagine, if we asked you, name others that you felt were in a similar situation.

David Bowles: To be clear, if you do not have performance problems, if you have no difficulty meeting targets, you would probably think the relationships are fine because you are having no great contact with them; you are just left alone to get on with it. It is when you start having problems. Discussions with others—I get in contact with quite a lot of people who phone me up about whistleblowing, which is one of the areas I am very active in—and the telephone calls I get from up and down the country paint a similar sort of pattern. There are, allegedly, some areas of the country where the strategic health authorities are rather more enlightened, where the chief executives perhaps have a different management style, but there is this deeply ingrained culture of making things look good, rather than things actually being good.

Q359 David Tredinnick: My question was specifically about what was going on at that time. I want to know whether you felt your situation was unusual or whether it was occurring across the country. Essentially, you are talking about the culture of threats and bullying—that is what I am talking about—from the Department: Barbara Hakin, I suppose.

David Bowles: Yes. If you read the 2009 NHS Confederation report, it talks about a climate of fear, intimidation and bullying. The 2008 reports talk about the public humiliation of CEOs as being the main improvement tool. That speaks for itself, doesn't it?

Q360 Rosie Cooper: Mr Walker, you indicate that your primary concern was patient safety at the trust. It is accepted that the trust had experience of a

dramatic rise in admissions to A and E during the winter of 2008, so I want to turn more to the clinician side of it. What discussions did you have with clinicians about the impact of that increased demand on patient safety issues? More precisely, did your medical staff committee discuss it? What was risk management doing? It is about the structures of the hospital: how did the problems that were created at that time feed into the committees that were set up directly to discuss those issues?

Gary Walker: There are two ways—formal and informal. The formal structures are around the board reports. Each one of those reports has performance figures and those sorts of things. It also has a quality report, so there are some contextual points put in there, not just data. Data is one thing, but events that are actually happening—incidents that are reported, those sorts of things—may come to the board. They would often be dealt with at sub-committees, like governance committees and things like that. Within those formal structures there are things like risk, risk management and all that. But there are also informal structures in terms of how I would be informed. I operated an open-door policy—

Q361 Rosie Cooper: Forgive me, but you are not answering the question I asked you. Your concerns were raised about patient safety. Therefore, I asked how you engaged with and got the opinion of the clinicians, be it informally, if you like, but also formally. The medical staff committee—surely, risk management—would have been very worried if patients were at risk.

Gary Walker: Indeed. I thought I was answering that.

Q362 Rosie Cooper: So let's deal with patient safety and clinicians, not all around it, please.

Gary Walker: Okay. I was about to come on to say that I do go and see clinicians and I was in part of those meetings. I would go down into the theatres and other places, and people would stop me, as well as all the formal reporting systems around risk management meetings and so on. They would deal with them, in terms of formal risk management, by looking at incident reports, looking at concerns that were raised by people. Medical staff in committees tend to talk about medical staffing, not necessarily risk management.

Q363 Rosie Cooper: Forgive me. You are talking to somebody who has chaired a hospital, so don't start to mix all the issues up. I understand what risk management does and I also understand what a medical staff committee does. But let me tell you, while it may start off talking just about how it does relate to that, the truth is that is the forum at which all the consultants—or most of the consultants who are available to attend—are sat round a table and, if there were patient safety issues, they would be talking about it. So what happened in your hospital? Did you talk about it?

Gary Walker: We would talk about all those things all the time. But you wouldn't talk about—

Q364 Rosie Cooper: So it is in the minutes.

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Gary Walker: I think you would find, if you looked at the minutes for all those meetings, you would quite happily find them. I had clinical directors running the various departments. We restructured to put doctors in charge, so managers were reporting to doctors in the trust, and it would be those clinical directors that would manage clinical incidents in their particular part of the organisation. They would come together into an executive team and tell me if there were any issues. The answer to, “Were they raising issues at the time?” is yes, they were.

Q365 Valerie Vaz: What sort of issues? Was it high mortality rates?

Gary Walker: I have detailed them in my—

Q366 Valerie Vaz: Can you detail them now? What was causing your concern? Was it the high mortality rates? Were patients waiting on trolleys? What exactly was it? I cannot get a handle on this.

Gary Walker: Certainly. There is a range of ways to look at problems, and I am trying to answer both questions. There are day-to-day issues—those are incidents that are happening because of the way things are happening today—and there are longer-term issues like HSMR and mortality rates. In terms of HSMR, back in 2008, we were concerned that we had a high mortality rate; we had an alert, but we did not know for certain. With regard to that response, because we could not get any reasonable information from the systems, Dr Foster or anything that would tell us the answer, we decided to do what no other trust had done at that point, which was to look at every single death in that hospital over the course of a year by looking at case notes and getting those reviewed by doctors and other clinicians who had not been involved. That would be how we approached things like mortality. In terms of operational and day-to-day concerns, people were coming to me and saying things. I give you a good example in there. I went down into the medical assessment unit, which is an area where emergency patients are taken, and there were trolleys lined up side by side that were so close together that you could not get between them. I asked whether they were in storage and was told that, no, they are in active use. I said, “That is not right.” If you had had experience of the Maidstone situation, where trolleys were put together, there was a huge cross-infection risk by doing that. The nurses came up to me and said, “We know it is wrong, but we were told to do it.” I said, “Who told you to do it?” It was a manager that I later dismissed, who then tried to produce evidence against me to get me dismissed.

These sorts of things were going on. The staff knew that there were problems, but they were too frightened to talk about it because everybody was obsessed with this culture in the NHS—not driven by me—that, if you do not deliver targets, that is it; you are finished. Actually, if you put patients at risk is the reason why you should be dismissed, not because of targets—

Q367 Valerie Vaz: Were they frightened to talk to you?

Gary Walker: No. The staff talked to me.

Q368 Valerie Vaz: Who were they frightened to talk to then?

Gary Walker: They were frightened to talk, in this particular case, to their manager. To give you examples of things that were going on, we would have clinicians raising concerns with me. There are other ways that clinicians raised concerns—things like trauma lists. Often, that would be very difficult. Trauma patients would come in and there would be too many trauma patients to treat. We all know—I do not know if the Committee does—in the health service that, if you do not operate on a fractured neck of femur in 72 hours, that is going to be a very bad outcome for that patient. There were various issues with trauma lists that were raised to me quite often, not necessarily through this period but increasingly over the next few months—March, April and May—as things went on. That is a result of having over-full hospitals. There is nowhere to put the patient post-operatively, and it is dangerous to leave them and so on. I could go on—

Q369 Chair: You are describing, Mr Walker, a hospital that is full and working under pressure. The question is, coming back to Andrew’s question around culture, what was it in the culture that prevented you taking the steps necessary as the man responsible in Lincoln for addressing the situation you describe?

Gary Walker: What I am describing is a period of heating up, if you like, of things getting worse and worse.

Chair: Absolutely, I understand that.

Gary Walker: We are only at the warm stage at the moment.

Q370 Chair: But you, as manager, should have identified that this was a problem that was developing. What were you doing about it?

Gary Walker: What I was doing was managing a hospital as safely as I could, which is, when I took the decision to cancel 700 operations, that was trying to manage the emergency side of the trust safely.

Q371 Rosie Cooper: Can we go back to what the clinicians were doing? If it was all unsafe, what were the clinicians doing about it?

Gary Walker: I am not saying it was unsafe then. The point I am making throughout the entire presentation here is that, in order to run a safe hospital, these things had to be done and I was doing x and y. What I was getting was pressure from outside saying that they wanted the targets delivered and, “We don’t care about that. We don’t care about the demand issues or your requests for a capacity review earlier in the year.”

Q372 Chair: With respect, you have told us they offered you a capacity review.

Gary Walker: No; the Department of Health did.

Q373 Chair: Indeed, the system offered you a capacity review.

Gary Walker: No; that is not the system.

David Bowles: Chairman, can I clarify that particular point? We are probably getting into quite a lot of detail here. The point is that the trust, as described to

me by clinicians, was at that tipping point. People were concerned that, if we continued putting pressure on the system, we would tip over from being a hospital that was just about coping. Unfortunately, there were an increasing number of slightly dodgy things, and I had had complaints about people having early discharges, for example, and then having to be readmitted and substandard care, but hopefully not actually killing people. We were at that tipping point. Mr Walker and the management team were saying, "We are going to cancel operations. We know that means we will not hit our targets. We are going to do this and we are going to do that to keep us on the right side of that tipping point." That is where we were here. Very early on in 2008, we had asked for a capacity review around only one or two specialties that were overheating. By the time we got to the turn of the year, we asked for a capacity review across the whole of the contract. I asked for it. The Department of Health—

Q374 Chair: When did you ask for it, Mr Bowles?

David Bowles: I asked for it, I think, in February 2008.

Q375 Chair: Was that 2008 or 2009?

David Bowles: I am sorry; it was 2009. I asked for it again in April 2009. I raised it with the regional chairman on numerous occasions. He completely refused to engage even in the conversation. I even had to send him an e-mail with the links showing what a capacity review was, and he refused to allow it and engage in a debate. I had a bizarre conversation with him where I said, "I am only prepared to meet these targets once we have our 100 new beds," and he said, "That is completely unacceptable. You have to meet your targets regardless of demand." From my personal objectives, he tried to strike out the caveats that I had put in, which said, "We will meet the targets when we have the 100 beds." I raised with the PCT chairman the capacity review. His comment was, "Everybody else is coping. Everybody else in the country is meeting them." Not everybody else in the country was meeting their targets, but his way of performance-managing the trust was to say, "Everybody else is coping." I am sorry, but I was in our situation rooms where staff were desperate for the next bed for an emergency patient and I was being told, "Treat your non-urgent patients." I found that absolutely scandalous.

Q376 Rosie Cooper: How many of your clinicians went on the record at that time?

David Bowles: You have a culture here; I will explain it to you.

Q377 Rosie Cooper: You don't need to.

David Bowles: The people who complained to me were the director of finance, the chief nursing officer, the director of performance, Mr Walker and our contract manager, who had all either received or witnessed—

Q378 Rosie Cooper: There is only one clinician in that list.

David Bowles: bullying and harassment.

Q379 Chair: By whom?

David Bowles: By staff of the SHA. When this review that we may get into in due course comes up—the Goodwin review—I am not confident that a single one of those people would have been prepared to say to Mr Goodwin what they said to me because, if you raise those concerns, your career will come to an end. That is the deep-rooted culture that we are dealing with here.

Q380 Rosie Cooper: You are accusing Neil Goodwin now of being a bully.

David Bowles: No. I am just saying that, if people do not have confidence in the confidentiality of the processes they are going through and believe that Mr Goodwin will report what was said—they do not think that what they say to him will be confidential—they are not going to say it.

Q381 Rosie Cooper: I did have more questions to ask, but we are going into very great detail and you have known your appearance here was going to take place for a number of weeks. Why did we only get a substantial amount of paperwork yesterday, not giving the Committee time to analyse and look at it in great detail? Why submit it yesterday morning?

Gary Walker: I wanted to submit to you what was relevant. I had not been in the country since I had the invite. I was invited to come here—but was not available—the week before last, I think it was. I had only just got back in the country. This is only 10% of the documents that were available for the employment tribunal. I have taken out all of the employment tribunal issues and tried to distil those that are relevant to here. That took me time because I am on my own to do it; I do not have a team of people to do it. There are 3,000 documents that I have distilled down to about 100 of those.

Q382 Rosie Cooper: Would it not have been better for you to ask for a later date, so you could give us a chance to look at the information you have submitted?

Gary Walker: I didn't think that that was—I thought the Committee was quite clear that they wanted me here. I am happy to adjourn if you want and come back again.

Q383 Chair: We would probably prefer to pursue it now that we are here.

David Bowles: Could I explain, Chairman, that in my case I was out of the country? I received the e-mail when I was out of the country asking for me to be here. I only got back and effectively had to work on this over the weekend and got it to you Sunday night. I apologise for that, but I literally was not back in the UK till Friday.

Q384 Mr Sharma: Let me say that it might be that the Chair will ask you to come back after a few weeks again to clarify many other things.

NHS East Midlands contends that it raised trust performance and governance issues with you in

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November 2008. Is it correct that they raised it with you?

David Bowles: I could comment on that. If you look to the period up to 2008, my own personal appraisals were things like, “Well above average; impressive performance; capability to be outstanding.” Those were my actual reviews. Mr Walker’s contract was renewed in July 2008, and it would be fair to say that Barbara Hakin would have been very disappointed if Mr Walker had left at that stage. She was really quite concerned that his contract should be renewed. What happened between then and Mr Walker being suspended and sacked and me being forced out is that our impressive performance becomes one of, “I am terribly sorry, but we demand a capacity review. We are going to put patients first. We are going to put safety first,” and them saying, “Meet targets regardless of demand.” What they subsequently did was launch reviews and investigations and so on to undermine people, to try and force you out. To this day, it is a great regret. If they had put that management time and effort into analysing Lincolnshire’s health economy, what was wrong with it and helping to improve it, we might have a better NHS. Instead, they acted in a way that is characterised in the Mid Staffordshire report as having a lack of candour and being target-driven, bullying and undermining. It is a great regret that they have produced that report today, which even says, “Mr Walker is not a whistleblower.”

Gary Walker: May I answer? The answer is no, not in those terms. Performance was not raised with me like that at all. As you will see over the next few months, lots of letters were written by Barbara Hakin that were not accurate accounts of the meetings. As a result of getting those letters, I had a choice either to write back to Barbara and correct her strange account, which I knew would then exacerbate the friction between the trust and the health authority because they were already being difficult towards me, or to speak to the board, essentially, of the trust, which I did, and I kept them informed from the very beginning that things were being said to me that were completely different from what was being recorded in these letters. Later on in the year, you will see that I wrote back to Barbara Hakin explaining that she had misinformed and essentially written stuff down that was not true.

The short answer is no, it was not raised as performance issues in any way like that. The only thing that I think was given to me from November 2008 was a typewritten note. I think it was a file note or something like that that Barbara Hakin had written following a meeting in November, and it was many months later that I had even seen that note. But it certainly was not something that was raised like that at the time—not at all.

Q385 Andrew Percy: Apologies for being a little late, Chairman. On this point, I was interested in your submission that you talk about the threat that was made to you in January 2008 after you declared a red alert, in which you go on to say that you were warned that Barbara Hakin considered there would be serious implications for you and that this had compromised the strategic health authority in the eyes of the

Minister, Ben Bradshaw. Later on in that year, we see from November that we have had the statement, which of course has just been raised with you. Do you think the change in the attitude of the strategic health authority towards you personally, and indeed to the trust, is as a result of what happened in January 2008 and that this undermined the strategic health authority?

Gary Walker: No. As I said earlier, I think that was more of an aberration—a one-off; I don’t know exactly. It was improper to be threatening me with red alert versus £11 million, but it is not uncommon in the health service to have those sorts of things said. I was not particularly concerned. I thought it was a threat, but I was not necessarily personally concerned at that time. The breakdown of relationships essentially came as a result of resisting the health authority’s pressure to remove me, which was driven by the fact that I was saying, “Hospitals are going to be unsafe if we carry on like this. I want things like mortality reviews. I want external support. If we cannot have a capacity review where we all work together, then I need some other solution to it.”

Of course, my solution was, “We will build more beds then.” Bear in mind that, at that time, the NHS was looking to reduce its size of acute facilities, not increase it; so to talk of building more beds, we were at odds with the entire trend of the whole NHS. In the end, just after I was forced out in July, the money was approved by the health authority and 100 beds were built. That is certainly an admission that there was a problem that required more capacity. During this process, I was being forced down a route to deliver the targets regardless of that demand. I think the reason for that is because targets were more important, particularly at that time. That is where I think the conflict came between the trust and the health authority, and that is when the relationship changed over the targets, not the year before.

Q386 Andrew Percy: This threat of removing funding you said is or was normal at the time. Is this the only example you had, or were there other examples in which you were threatened that you would suffer financially as a trust if you continued to—

Gary Walker: Not from the strategic health authority, no.

Q387 Andrew Percy: But from elsewhere—from the Department directly.

Gary Walker: I have spent 20 years in the health service and behaviours like that do exist.

Q388 Barbara Keeley: Before I come on to other questions, you talked about the excess demand, the increase in demand, 100 additional beds needed per week and the level of occupancy. This is a straightforward question. Where was that demand coming from? What were the issues in your local community or population that were causing that huge demand that maybe other hospitals were or were not experiencing?

Gary Walker: The irony is that we were asking a year before for a capacity review and we could have found out the answer to that question.

Q389 Barbara Keeley: You must have discussed it.

Gary Walker: As an acute hospital, most of your money, time and people are spent on running the hospital, not examining the system around it. The system around it is the responsibility of the primary care trust, and that was our first port of call. "Can you manage the demand?" because that is their statutory duty; but they were not interested in engaging. They were actually quite silent throughout most of the process, not responding to calls for any sort of joint working. We tried several times to get them to sign a document that said they were interested in joint working. We even quoted the NHS Act at them in the end and said, "There is a duty on you to work together, not just to have this buyer-supplier-type approach." They would not. They were not interested—not interested at all.

Q390 Barbara Keeley: As to the capacity review that you were asking for—I am not sure—who would have carried that out? Who would you have expected to carry that out?

Gary Walker: It would have been a third party.

Q391 Barbara Keeley: Did you follow up on the Department of Health offer? When you talked about the teleconference and the presentation, I think you said, "Ironically, they had offered a review."

Gary Walker: Yes. I would have loved to have done so if I had stayed in my job.

Q392 Chair: You were there another year.

Gary Walker: No, I wasn't. I was actually only there for another couple of months and then I was asked to stay at home.

Q393 Barbara Keeley: They did not come through with any letter or follow-up or anything on that offer.

Gary Walker: No.

Q394 Barbara Keeley: It was just a verbal offer.

Gary Walker: Yes. I think his name was Nick Chapman.

Q395 Barbara Keeley: You might not have things to add because my colleague Andrew Percy has just asked a similar question, but Mr Bowles has characterised the approach that he associated with the trust and has talked about issues from before when he was appointed. It is largely about being on the radar—presumably, from when you went on red alert, you were on the radar—and, if you had not had performance issues, your relationships might have stayed okay. Did that relationship wax and wane? Did it improve at any point, or throughout this period you are talking about was it that things just degraded?

Gary Walker: I would not say I had much of a relationship with Barbara Hakin prior to that. It was very professional and we did not talk that much. There was not a lot going on. There were a few things that I was asked to do region-wide, which was things like

chairing the critical care network and things like that, but, other than that there was not really any contact more than a few phone calls. It was only when we started to suggest that we may miss the targets that the interest started. Then, of course, because nothing changed around demand, we then said, "We are definitely going to miss the targets," and that is when it became very personal.

Q396 Barbara Keeley: We have touched on issues of bullying and harassment. Can you tell us when and with whom you raised concerns about bullying and harassment? I think I made a note that you first felt in January or February 2009 that there were threats to two of the staff in conversations. Then, if you move us through, because that is a big part of what you are saying, I think it is quite important to understand where you felt that was coming in, who was affected and who you talked about it with.

Gary Walker: Any time that I considered it to be a formal threat of bullying and harassment I mentioned it to the board. You will not have seen it, I guess, but at annex F to my statement there is a list of 16 protected disclosures, which gives you an idea of the number of times that I had raised concerns about some improper practice that was qualified under the whistleblowing Act. It does not necessarily cover all of the issues of bullying, but these are the more extreme ones, if you like, where patients may have come to harm or a code of conduct was broken. It starts in January 2008—obviously, there were times there—and then it picks up again in February, where we have got to in the timeline. Then, from February onwards, there are 14 more occasions where all of those were reported to the board and then eventually reported to—well, some of my disclosures to the health authority are technically whistleblowing disclosures. Then, of course, I wrote to David Nicholson and told him all about it.

Q397 Barbara Keeley: That was in July 2009.

Gary Walker: That is right. It is very well documented through minutes of remuneration committees and other things.

David Bowles: This was a particularly difficult issue. As far as the remuneration committee was concerned, we were caught in that we had had a number of complaints from staff. We had passed a resolution at a board meeting in January 2009 that made it clear to the executive team that, if they experienced bullying, they would be protected by the trust. That is formally recorded in the trust board minutes. That was about as far as we could go, because none of those who complained to me were prepared to allow me to raise the issue directly with the strategic health authority and to make the specific allegations about named individuals in the strategic health authority. The basis for that was quite clear—that their careers would come to an end the minute I made the formal complaint on their behalf.

I make this comment because I was absolutely shocked that that was the response. In fact, the debates among the non-executive directors on the remuneration committee were, "Are we dealing with the Mafia?" That was the nature and tone of the

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conversations of the non-executive directors on the remuneration committee. We wrote to Mr Walker and advised him that, when he met officers of the strategic health authority, he should have a colleague with him to witness and take minutes of what actually happened, and, finally, we advised Mr Walker that he should bypass the strategic health authority and raise complaints directly with David Nicholson. To this day, I feel I let everybody down.

Q398 Chair: As to this pattern of behaviour that you say the trust board discussed in January 2009, did you raise that at the time with the chairman of the SHA?

David Bowles: The very clear steer that I got from those people who had raised the issues with me was that they absolutely did not want it raised with the strategic health authority. I sought advice as well from our head of HR on what we should do as a good employer and so offered counselling and support. All of those sorts of things we tried to do.

Q399 Chair: With respect, Mr Bowles, you do not have to identify any employee. If you have a concern about a pattern of behaviour within the SHA, that surely is an issue of public concern that goes way beyond the concerns of an individual employee about their employment.

David Bowles: If you raise those concerns, for those concerns to be identified and addressed correctly and accurately, you have to identify who was the recipient of the bullying behaviour and who was the perpetrator.

Q400 Chair: You have to open a discussion, don't you? Of course, if you are going to root it out, then you have to deal with instances, but is the answer to the question, "Did you raise it with the chairman of the SHA?" no?

David Bowles: I certainly raised my concerns about the general tenor, tone and the pressure on targets. I raised that on many occasions.

Q401 Chair: I am asking a specific question. You are making a very serious allegation that the relationships between individual senior employees of the trust and their counterparts in the SHA were such as to make it impossible for them to do their jobs because of their concern about their future employment in the NHS.

David Bowles: I raised it in very general terms about pressure. I raised it with David Nicholson directly. Again, I took the choice that—

Q402 Mr Sharma: Was it passing remarks or a serious discussion?

David Bowles: The problem is that I, too, experienced it. What is the point in going to John Brigstocke to complain when he absolutely lost it with me? "Lost it" is the way I would describe it when I said absolutely bluntly, "I am not prepared to give you a guarantee that we will meet targets until the 100 beds are built." I formally raised concerns about John Brigstocke's behaviour towards me with David Nicholson. So I was the recipient of that conduct and behaviour as well. I was prepared to do that on my behalf—I am prepared to go public and to write to David Nicholson and identify myself as a recipient of

bullying behaviour—but I am not prepared to do it in such a way that it would destroy people's careers. If you look at Gary now, Gary blew the whistle, applied for 50 or 60 jobs and has not got even one interview. That is the culture you are dealing with here.

Q403 Chair: What I am hearing is that Mr Walker has made the case that there was a capacity issue that was growing from the summer of 2008, but right through to his departure in the summer of 2009—a year later—no capacity review took place. That is in my mind a serious strategic failure by a senior manager, and you, as the chairman, are describing a culture that makes it impossible for the senior structure of the Lincolnshire trust to relate to the strategic health authority. Apart from generally raising it, it was not an issue. Yours is not an NHS career and there is no career on the line in your case. It seems to me that you owed it to your position as chairman of the trust to take more seriously the concern you are now expressing to the Committee about the culture that made the job impossible to do.

Gary Walker: Do you mind if I say something? You are possibly missing the aspect of the culture that is so severe. The people involved—the directors who worked for me—raised concerns, but equally said, "If we speak out about these concerns, that is it; we don't have a career. We all have lives and mortgages and so on." Things changed later as we go through the timeline, but at that stage people were saying, "This is outrageous behaviour, but if we stand up now we are just going to get shot like everybody else does."

Q404 Chair: All right. I am repeating what I am hearing.

David Bowles: I agree with you, Chairman, that I found it very uncomfortable to be in that position—very uncomfortable indeed—and, to this day, I question whether I handled it properly. My real fear is that, if I had handled it in the way that I would have preferred to have done, we would have more people unemployed like Mr Walker.

Q405 Chair: We need to reserve time to discuss the compromise agreement that I know Sarah wants to come on to. Can we complete the discussion of the timeline to the point where you were—

Gary Walker: Indeed. I will deal with that in the next few minutes. You have had a quick read of the briefing. I am at about paragraph 49, moving on to March 2009. There is an example there of e-mails that came through from Barbara Hakin and the chairman, a joint e-mail, and I give you the quote: "The consequences of not meeting this national target"—in reference to A and E—"in the East Midlands overall could be considerable." What consequences? We are going back to the context now. What consequences are there? Why is an e-mail coming through to say there will be consequences for not achieving the target? I am not really sure how anybody can interpret that other than the way that I have described in my note.

In April 2009, things are now obviously getting very difficult. I have had a director, who himself is a clinician, say to me that something is going to go very

wrong in this organisation. He was my director of performance. He is obviously looking at the data at the time. The data at that time was that the hospitals were 100% full—I mean, on average, 100% full. There is no time between patients in and out of beds. People are on trolleys and that kind of thing. This is a dangerous place to be.

Q406 Chair: But there is still no capacity review.

Gary Walker: We had gone beyond a capacity review, in my opinion, at this point. This was now into crisis management.

Q407 Chair: That is understood. You have to manage the crisis, but you also have to address the cause of the crisis.

Gary Walker: Indeed. It is not within my gift to organise a capacity review for a health system. I am a provider of services in the system. I had asked for it.

Q408 Rosie Cooper: You would not have lost your job for pursuing that. The argument you are using is, “If I do x, y and z, our careers are threatened,” but actually getting a capacity review is a neutral thing, is it not? They have offered it, you want it—

David Bowles: I am sorry, Chair, but, if I may interrupt, I raised the capacity review directly with the chairman of the PCT and the chairman of the strategic health authority on numerous occasions. There was an absolute flat refusal. My belief is that the reason they refused it was that, if they agreed to a capacity review, it would be an acknowledgment that their plan to divert capacity away from the acute sector into other areas had abysmally failed, and they would have required, as Gary Walker said earlier, to go up the line to the Department of Health and say, “ULHT is temporarily relieved from having to meet the 18-week target, while we carry out a capacity review and re-plan services in Lincolnshire.” I believe the reason they were not prepared to carry out a capacity review was because that would have looked very bad up the line. This is an organisation that had already—

Q409 Chair: But from the top of the line, Mr Walker just told us, they offered it.

David Bowles: Yes; it may have been offered by the Department, or suggested by the Department, and that is all very well and good; but under the contract, it has to be commissioned by the PCT or the SHA, and they refused. It is just part of the cover-up, I am afraid. So our tactic was a bid for 100 beds, and that was sitting on the SHA's table.

Andrew Percy: We see this now as Members of Parliament, don't we? We have huge problems in my local hospital that is on purple alert, and whenever we try to raise the issue about bed numbers, we are told repeatedly, “There is not an issue with bed numbers. It is all about trying to divert people into their own home for care,” and all the rest of it. You are not able to question properly. I get the impression that it is, “The general direction of travel is that we need to lose more beds from our hospitals, and anybody who questions that is against modern healthcare or doesn't know what they are talking about.” We have a huge campaign in my own constituency at the moment

around beds, and what we come up against the whole time is a brick wall of, “How dare you raise and question the number of beds in our hospitals? It is not acceptable. That is not the direction of travel.” So I get this entirely because we are seeing it in my part of Lincolnshire right now.

Chair: Except that in this case, in the discussion with the Department of Health, the review was offered.

Andrew Percy: But it has got to be deliverable. Who is going to deliver it?

Q410 Barbara Keeley: We have just been told that the PCT would have to have carried it out, but the PCT was not willing to do so. Did they at any point document—or was it just verbal—the refusals to carry out a capacity review?

David Bowles: It was verbal but it was also quite explicit in the correspondence I received. The correspondence I received said things like, “We should fine you because you are not meeting the targets.” I am sorry, but they could not fine us because we were over-performing the contract. It said things like, “A look back at history shows that there is nothing unusual going on here. Everybody else is coping. Meet your targets.” The capacity review has to be triggered by the PCT in recognition of, “There is a problem.” They frankly refused to accept there was a problem.

Q411 Rosie Cooper: Can I try this one more time? Bearing in mind where you have ended up, just go back to the capacity review. It has been offered to you by the Department of Health. You suggest it has to be commissioned by the PCT. Did you ever go back to the Department of Health and say, “The PCT has not commissioned it. We are desperate”? All of this has gone on; all the clinicians and the whole hospital is in disarray because you fear for patient safety. Did you go back to the Department of Health and say, “Where is it?”

David Bowles: I went back to David Nicholson personally in July 2009.

Q412 Rosie Cooper: Was David Nicholson in the Department of Health? What was the timeline there?

David Bowles: Yes. He was chief executive of the Department of Health, yes.

Gary Walker: Throughout this period.

David Bowles: Throughout this period.

Q413 Rosie Cooper: You went to him personally.

David Bowles: I wrote to him personally on it.

Q414 Rosie Cooper: What response did you get?

David Bowles: “The Goodwin review”, which never even looked at capacity review.

Gary Walker: Or safety.

David Bowles: Or safety. I wrote to David Nicholson in July 2009, raising my concerns that they had repeatedly refused to conduct a capacity review.

Q415 Chair: But this was at the end of the process in terms of your own tenure as chairman and Mr Walker's effective tenure as chief executive.

David Bowles: Yes.

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Q416 Chair: The period when this crisis was developing, as you have told us, was from 12 months before that.

David Bowles: I think, with respect, Chairman, you have to understand that, during the February to March 2009 period, the PCT's line was, "Yes, we know you are running a bit hot, but it is winter pressures; it is winter pressures; it is winter pressures." Then, come April, we had our record number of emergency admissions. In June, we had another record number of emergency admissions, and in July we had another record of emergency admissions. At that point you say, "No, this is not winter pressures. This is something fundamentally out of kilter." So you go from, "There is half an argument here about a capacity review because it might be a blip." If you look at the performance data across the NHS as a whole, you will see that in January and February 2009 there was a peak in demand. The PCT was arguing, "No, this is just rather extreme winter pressures." Their contract from April 2009 onwards was over-performing from April 2009. When I sat down with John Brigstocke and said, "This is not winter pressures. We have had record emergency admissions in June 2009," he was still not interested.

Q417 Chair: We have probably done that subject to death. Are there other points in the evolution of the timeline in the spring and summer of 2009?

Gary Walker: There are a few. I will go from April 2009 to July, because that was the last time I was there. I will move through that quite quickly. So now we are in April 2009. I meet Barbara Hakin after asking her for various things, talking to her about patient safety concerns that have been expressed to me, asking for external help in carrying out work around mortality. She was not really interested in talking to me about that at all. She met me in a hotel reception and said that, if I did not go, my career would be "in tatters". She went on and asked me to make up a story to tell my chairman that I would be leaving because it was my decision to go, and later on she did try and find me another job somewhere. Bearing in mind what I have just said about the environment, there was no other performance issue other than we had said, "We can't hit the targets because of the demand." There was no performance management in that sense at all, and no analysis has ever been undertaken as to why demand was so high. In Dame Barbara's witness statement, which is again a document that would have been sworn into a court, she says, "The reference to 'constructing a story' was to protect Gary." I do not understand any of that. It is an acceptance that Dame Barbara was in fact asking me to lie to my chairman. It is also an acceptance that I needed some form of protection.

We have already covered the issues of me being told to deliver targets whatever demand. There is a document in the bundle that you will see eventually with Barbara Hakin's handwritten note of that comment, which is a very common comment, "You must deliver the targets whatever demand." If you are running a hospital that is full up, and dangerously full up, and you are cancelling patients left right and

centre, to just blindly go on and deliver targets is totally wrong because you are going to cause harm.

Then there are threatening letters going to the chairman now talking about me—this is in May—where the chairman is reminded that Barbara Hakin's formal authority is limited to removing my accountable officer status. What that means is that the employer—the trust—would not be able to employ me if I did not have accountable officer status. If it is removed, I will be dismissed.

Q418 Chair: The reason you have done this is just—

Gary Walker: It is a threat. You want to talk about the culture. I am trying to tell you there is a culture of threats and intimidation. Again, there is no performance management, no other issues apart from the fact that I was telling them we could not deliver the targets. Bear in mind, let's not forget, that, as soon as I am out of the way, 100 beds are built in recognition of the fact that there is not enough capacity, which is what I was saying all along.

Then there is a period in May where Barbara Hakin asked me to stay and then changed her mind the next week.

Then there is the Catherine Elcoat report that was commissioned around June 2009. The summary of that, if you refer to paragraph 66 of my statement, is quite clear. It gives you some of the numbers there. It says that care was good and there were no questions about the quality of care at that time. The reason it is good is because that is what we were trying to do. We were trying to keep the quality up, not necessarily, unfortunately, hitting the target. The report did say that the staff were very tired. I agree with that. That is the case when running hospitals where everybody is flat out; they are going to be very tired. Again, that has its own risks. This continued on for a while.

I will skip now to July 2009, where, because of the threats against me and the forcing out of the chairman the day before, I realised that because I had not agreed to go they were now going after the chairman, to put a new chairman in to remove me. That is a very common practice that has happened over the years in the NHS. So I wrote to David Nicholson, explaining everything that had gone on. I noticed that yesterday at the Public Accounts Committee he denied any of the following that I am about to say, but if you want to read the letter it is quite clear. I disclosed to him the threat to patient health and safety due to the fact that I was being forced to comply with targets; the threat to the health and safety of patients due to the SHA bullying of members of the ULHT staff; then that I was asked to leave my post, which is also bullying and intimidation; and that the various reviews that the health authority had carried out, which I am happy to talk about a bit more, were biased and flawed. I asked for protection as a whistleblower in that letter in the last paragraph, and, as I said, yesterday at the Public Accounts Committee, David Nicholson denied all of that.

Immediately after that various reviews were published. There was the Garland review, and I have never seen a final version of that. It was critical in one sense but accepted that there was a system-wide problem of capacity that needed to be resolved. So,

again, it is system-wide. In fact, I wrote to Sir David three times, including Andy Burnham once as well, trying to get some reaction to protect me and deal with the things that were going on around forcing people to hit targets.

Then there was an inexplicable series of events involving the media where Barbara Hakin went on to various programmes and attacked me personally. That is, again, in the document. John Brigstocke—the chairman of the health authority—went on again and attacked me. He said things like “standards had been maintained”—and then went on to say—“by poor governance”, which does not make any sense to me at all. But these were the sorts of things that were going on.

I am in the newspapers with comments such as, “Management of Lincolnshire’s hospitals has been criticised and the chief executive’s job is on the line.” I do not need to go on about them because there is plenty in there for you to read, but there was no performance management of me, no normal process that you would have in these sorts of situations, the reason being that there were no performance issues; there was simply a board trying to do the right thing around patients, and that was not greeted well by Barbara Hakin.

There was now a discussion between Barbara Hakin and the new chairman, Paul Richardson, about whether my job was tenable. Again, what process had there been to determine that?

Goodwin is then appointed. Goodwin’s review was very interesting in the sense that I had reported health and safety issues that I had just described to David Nicholson, but David Nicholson set up an inquiry that did not look at patient safety issues and really did not look at a number of things. One of the things that that report did not look at was the SHA or Barbara Hakin’s attempts to remove me over several months. It decided that there was only a need to look at written evidence of bullying because verbal evidence was not of any weight. In my opinion, you would have to be fairly clumsy to be writing down bullying. Most bullying is done in the way that I have described and it has in fact been accepted by Barbara Hakin that she did in fact do so.

There was no mention of a capacity review in the Goodwin report—not once. We have just covered it at great length. There was no mention, for example, that Barbara Hakin was writing to me and copying it to all her staff, saying that I was going to leave even when I was not. David Nicholson went on to say that he was not going to check for factual accuracy of the Goodwin report because there was no need to. So the report was published without any checking. I have never come across that; when you write a report, there is always a checking phase, but not in this case. The various documents that I have referred to, such as Barbara Hakin’s handwritten note and her acceptance that she bullied staff and other things, were all released a few days after the Goodwin review was published, even though they had been under an FOI request for months.

I have made my conclusions there. As you can see, in my view, Goodwin is involved in other whistleblowing cases that have been proven in court

and therefore I question his standing. The media did question his standing at the time because Neil Goodwin had previously worked for Barbara Hakin, whom he was now investigating, and the health authority was a client. He was also a health authority chief exec previously.

Of most concern to me after that, though, was that not only did Sir David say there was no evidence of bullying whatsoever, which is not true, and it is not actually what the full report says that there is no bullying whatsoever—the full report has only, I think, last week been released by the Department of Health, so it is available, or it is imminently going to be available, but I have included it in this bundle—but it says that there were differing accounts and that there clearly was evidence.

We asked for a number of people to be interviewed by Goodwin who had relevant knowledge—for example, the director of operations, who was threatened by Barbara Hakin, to whom Barbara Hakin accepts that she did say, “If you can’t manage an A and E, you can’t run a hospital”—but Goodwin refused to interview her. So people with relevant information were not included in the review. For those reasons, I think it is dangerous for the Department of Health to stand by that as being thorough in any way. I have a concluding remark there just before we get on to the things around the compromise agreement, and I would like to mention the Care Quality Commission.

I will only mention one aspect of the employment tribunal. The reason it is relevant here is that I made a note of one of the hearings against me, and during that employment tribunal, I mentioned that the reason I was there, the reason the action was being taken against me, was because of whistleblowing and protected disclosures and everything to do with the health authority. I mentioned that six times during the four hours of the disciplinary panel. All references to whistleblowing and the health authority were removed from the minutes of that meeting. The reason why maybe people say that I am not a whistleblower is because, every time I say it, it is deleted from the record. This is just not a way to govern public services. The records of those hearings have been adjusted specifically.

Q419 Chair: You are saying this is the record of the employment tribunal.

Gary Walker: The record of the disciplinary panel, which was a verbatim transcript, had all references to my claim to be a whistleblower removed.

Q420 David Tredinnick: There is a sort of legal context of a whistleblower, I think I am right in saying. The NHS East Midlands just challenges your contention that you are a whistleblower because you raised concerns about patient care. They have told us that there has never been any finding that you have raised genuine concerns that would constitute your designation as a whistleblower. How do you respond to that assertion?

Gary Walker: I think they are trying to play a legal trick of saying you can only be a whistleblower in this country if there is a finding in a court. The general

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public would say that actually you can be a whistleblower and not have to go to court. I think the argument that they are putting forward—it has clearly been written by lawyers—is that a finding means a legal finding, and the only legal finding you can have is in court. I do not hold with that at all because that would mean there are really hardly any whistleblowers, and that is just not true.

David Bowles: The other point that is relevant, if I may, Chairman, is that you do a commercial analysis when you settle a dispute before the employment tribunal. If you do not believe anybody has the remotest chance of winning the whistleblowing claim, then your maximum level of damages is likely to be £50,000 or £60,000. Mr Walker's settlement was substantially more than that, which means that, on a commercial basis, somebody somewhere thought that Mr Walker was going to win an uncapped claim, which would be that they thought in a tribunal he would win and get a finding that he was a whistleblower. I think those sorts of comments by the Department or by the East Midlands Strategic Health Authority are misleading and disingenuous.

Q421 Rosie Cooper: So how much was it settled for?

Gary Walker: The payment to me was £325,000, and that included £100,000 of legal fees that the NHS settled directly with my lawyers; so they paid my legal fees. I received £225,000, roughly. That included a payment for injury to feelings and all sorts of other compensatory payments. But the total was that amount.

Q422 Chair: The total in the compromise agreement that is blanked out in the copy was £225,000.

Gary Walker: Yes. I am happy to give you that. I was concerned that you may publish the compromise agreement, so I left that out, but I am happy for you to have one. That is what is behind that blanked-out bit, yes.

Q423 Valerie Vaz: Can I go back to my colleague David Tredinnick's question and the Public Interest Disclosure Act—the PIDA? Did you have advice about whether the clauses in your agreement were covered by the Act?

Gary Walker: Do you mean advice in terms of my legal advice?

Q424 Valerie Vaz: Yes. You know they are void, don't you? Anything in an agreement is void. Were you aware of the difference between whether the allegations you were making were protected or non-protected?

Gary Walker: I had a meeting with the lawyers about the specific subject. They said, "In theory, yes, you are right, but that does not stop them from suing you."

Q425 Valerie Vaz: Okay; so you knew you were protected.

Gary Walker: No. In theory, you are—

Q426 Valerie Vaz: You can still be protected and someone can still sue you—

Gary Walker: In theory, you are protected, but the only way you can prove you are protected—

Q427 Valerie Vaz: because that is your defence, isn't it?

Gary Walker: is after you have spent £100,000 going to court to defend yourself.

Q428 Valerie Vaz: That is not what I was asking. I was just wondering whether you knew, because the Act exists.

Gary Walker: I agree.

Q429 Valerie Vaz: We are trying to find out whether the Act is sufficient for whistleblowers.

Gary Walker: I am involved in a commission with Public Concern at Work that is looking at this for the next six months, because I think the intention of the Act is not quite being delivered in the real world. Yes, the Act is good in principle, but it is a very difficultly worded Act that is not very easy for people to use. To be honest, my view is that we should not be using it because, particularly in the health service, it should not really be needed. Concerns should be acted on and people should not have to go to court and use an Act.

Q430 Valerie Vaz: Was there any finding—I do not know because we got some of the papers quite late—in the employment tribunal? You had some pre-hearings, didn't you?

Gary Walker: Yes, we had a pre-hearing.

Q431 Valerie Vaz: Was there a finding that you were covered by the Act?

Gary Walker: What the employment judge said was that he looked at various things like the correspondence between me and David Nicholson, and the correspondence between me and Barbara Hakin. He obviously could not look at the verbal things because a fully constituted tribunal is needed to do that. He said they were prima facie protected disclosures. There are three standards for protected disclosures. One is that it has to be a qualifying disclosure, so it must relate to something that is qualifying in the Act, which is fraud, breach of codes, patient safety, that kind of thing. That is a qualifying act. The next trigger is good faith, and that is something that can be found in a tribunal, but, as you know, the law is just about to change on that, so good faith will not be a requirement for a finding any more; it will be a requirement for costs. The third stage is, "Was it the principal cause of your dismissal? Was that the reason you were really dismissed?" Obviously, we did not get to that stage.

Q432 Valerie Vaz: But certainly you felt that what you were raising was information as opposed to allegations.

Gary Walker: No. I was quite specific that patients were going to come to harm if this continued. PIDA should not operate after people have come to harm. The principle of PIDA is to avoid things going wrong.

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Q433 Valerie Vaz: I am just asking if you thought that what you were raising was information or allegations.

Gary Walker: It was a mixture of both, because it depends at which stage the disclosures are made. At one stage, it is saying things could happen, and then, eventually, it is saying things are probably happening; actually, no, they are at imminent risk. So it was an escalating process.

Q434 Valerie Vaz: One of the judges—I think it is Mrs Justice Slade—has made a kind of definition about the two, so information is protected and allegations aren't protected.

Gary Walker: Yes, that's right.

Q435 Valerie Vaz: You felt you had a mixture of both.

Gary Walker: It is going to be a mixture of the two, and that would have been the argument over the 16 protected disclosures in terms of legal position. But we are going down a very legalistic route and I am not a qualified lawyer, but—

Q436 Valerie Vaz: It is your case and sometimes you can get very good at understanding law.

Gary Walker: Unfortunately, yes, and during this process I did in fact do a law degree, but that still does not make me a lawyer. I would not say it was not necessarily a finding or a determination in a legal sense, but it was an opinion of a judge that they were protected disclosures, and, therefore, in my opinion, that does make you a whistleblower by a judicial process even though it is not a full finding of a tribunal.

Q437 Valerie Vaz: I have one last question. Why did you settle?

Gary Walker: Why did I settle? By the time I got to the tribunal—it was on the first day and the proceedings were stayed for a day, so that judicial mediation could go ahead—I owed £100,000 to the lawyers at that point, the mortgage was in arrears, and, quite frankly, the whole family had just had too much of it, and I had as well. I was exhausted. Fighting your own legal case for a lot of the time—although I had lawyers towards the end of it—was just exhausting.

Q438 Dr Wollaston: You have said that you do not wish us to publish the compromise agreement. Why is that?

Gary Walker: There isn't a reason now because I have probably covered everything in it, but at the time of putting this together I was not quite sure. I am happy for it to be published.

Q439 Dr Wollaston: You are happy for that to be published. Thank you very much for clarifying it. Did you attempt to contest the gagging clause as it related to material that you believed should be in the public domain?

Gary Walker: In the sense that I had met with the lawyers and said to them, "Can I break the gag? Can I actually go out?" They said, again, "In theory, you can, but there is still a chance that they will sue you

and try to say that you were not a whistleblower," despite the fact that—

Q440 Chair: Which clause do you regard as being a gagging clause in this agreement?

Gary Walker: If you have the agreement in front of you, it is section 6.

Q441 Chair: It is the clause that says, "You will not make any detrimental or derogatory statements..."

Gary Walker: No. That is, I think, what Robert Francis referred to as a non-disparagement agreement, and that is actually quite normal. The phrase I am talking about is under section 6, in 1.3, where it says: "You agree that the dispute between you and the Respondent,"—that would be my employer, the NHS trust in Lincolnshire—"the East Midlands SHA, the Department of Health and the Appointments Commission is hereby at an end and shall not repeat the allegations contained in your witness statements which were served on the Respondent during the proceedings."

It goes on to say, just for information there: "You agree to take reasonable steps by asking the other witnesses to abide by the same duties..." Essentially, it is asking me to gag the witnesses as well.

The allegations contained in my witness statement that are referred to here include what I have said to you, but obviously there is more detail in there if we had had more time to go through that. But it is very clear that I had made allegations principally only about Barbara Hakin and David Nicholson not treating me as a whistleblower correctly, not taking the appropriate response and forcing me out of the position on charges that witnesses have said were fabricated. There are a number of allegations in there, as well as all the issues that we have discussed around patient safety—the threats made to staff because they were not going to deliver the targets. Of course, since that time, harm has come to patients and we know that now, and I am happy to talk about the CQC involvement, unless you have any more questions on that.

David Bowles: Before we do that, Chairman, may I make a comment? I, too, was the recipient of a gagging letter. I find it absolutely extraordinary that this gagging clause seeks to gag witnesses in a tribunal as well. That really puzzled me because I had never ever heard of that sort of thing before. It is absolutely unprecedented. My daughter is an employment lawyer, and she has never come across that in her life. But I received three documents under a freedom of information and data subject access request, and I believe it was those three documents that they were particularly concerned about.

The first document is in my information pack at page 19. This is a report from the SHA's own analysts, which expresses concerns that Lincolnshire's hospitals are over-full and are potentially, therefore, a danger to patients. That is on page 19. The SHA's own analysts are raising alarms that these hospitals are potentially dangerous—medical outliers, hospital-acquired infection may get out of control. You have to contrast that with page 21, where there is an e-mail from Sir John Brigstocke, which basically says, "Meet your

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targets regardless of demand.” There is no let-out clause; it is basically denying a capacity review. There is Barbara Hakin’s handwritten note on page 22, which says, “Need to meet targets whatever demand.” I got those three documents through a data subject access request. As I say, I received them a few days after the Goodwin report was published. I don’t believe that is a coincidence, so Goodwin, I assume, did not have those documents. I can only presume that they tried to extend the gag to me to try and prevent those three documents getting into the public domain, because they are really quite damaging to Barbara Hakin. Her own staff are saying, “These hospitals are very full,” and she is saying, “Meet targets whatever demand.”

Q442 Andrew George: Can I query the extent to which, in your report, these things happened because, once again, bringing it back to the broader issue of the culture within the NHS, I can quite see that there is a dispute or even a clash of personalities that was developing over time as well? To what extent were the concerns about patient safety, which is surely the primary concern here, concerns about patient safety that you were wishing to express? This evidence came in after the dispute was already running its course. You were already well into the process. You were at the point of going into tribunal and giving evidence at that point. For example, in the days when you were raising concerns about patient safety, and there were the usual stories to the public from the SHA, “Oh, well, this is entirely down to exceptional winter pressures,” were you repeating the same kind of reassurances, or were you saying, “This is a capacity issue, and we are not being given the resources necessary in order to be able to assure people of patient safety in the hospital.”?

David Bowles: First of all, all of these documents are dated April 2009 or thereabouts, so they were right at the very heart of that debate with the strategic health authority.

Q443 Andrew George: When did you receive them?

David Bowles: I did not receive them until October 2009. These were internal documents within the SHA. The analysts in the SHA had said, “Lincolnshire’s hospitals are a bit full. This could be a bit tricky,” and the two most senior people in the East Midlands Strategic Health Authority—the chairman and the chief exec—are both saying, “Meet your targets,” when their own staff are saying, “These hospitals are dangerously over-full.” Those documents came to me, and I am trying to reconcile why witnesses were gagged. I got those documents and I provided them to Mr Walker. But the issues of the capacity review and safety were ongoing from February 2009 onwards, and I think it really became an issue from April or May when you suddenly could prove it was not a winter pressure and it really became very serious. At that point, up till then, you were thinking, “This might be a blip. It might duck down and we will be back to running a bit hot but safe,” and from that point on—April to May time—we suddenly realised that this was going to carry on.

Q444 Andrew George: Was there ever any attempt to contradict or challenge the instructions given by Sir John Brigstocke and Barbara Hakin?

David Bowles: Yes, and the way we did it—

Q445 Andrew George: Were any of those notes ever challenged by anybody? Were they saying, “Surely, this is not right. Patient safety is being compromised here.”?

David Bowles: Yes. These were things that had been said to me. These are things that I had e-mailed back and I had private notes of. These are examples of what was actually going on within the SHA itself. These are documents that were only circulating in the SHA at the time. That is why I think it is particularly damning. They were not made available to Goodwin, as far as I can tell. But it does show the mindset that, on the one hand, you have the analysts saying, “These hospitals are full,” and on the other, you have the two most senior people saying, “Meet your targets.”

Q446 Rosie Cooper: Can I just carry on Andrew’s point and ask you a direct question? All this time when you were worried about patient safety—and we now know that from Mr Bowles’ evidence the strategic health authority were aware—will I find any comments in the press, letters to MPs or complaint letters signed off by you where you did not say you had concerns but you actually reflected the story that the strategic health authority are saying?

David Bowles: If I might answer that—

Q447 Rosie Cooper: But you were the chief executive and you would have signed the letters.

Gary Walker: There are a number of questions in there. Did I raise any of the issues that I am saying now in public? I would have obviously been in the media during that period of time talking about the safety of hospitals and other things.

Q448 Rosie Cooper: Did you lie then? That is the question. In those letters, did you—

Gary Walker: Did I what, sorry?

Q449 Rosie Cooper: “Lie” maybe is too strong a word. Did you trot out another line? If there are any letters where you reflect—

Gary Walker: I do not actually think that a chief exec should spend too much time with MPs; that is the role of chairmen of trusts. Chief execs should spend most of their time—

Q450 Rosie Cooper: What about complaints letters? Let us not deflect it.

Gary Walker: You asked the question, “Did the MPs know?”

Q451 Rosie Cooper: Let us deal with the press and complaints letters. I am asking you the question, not the chairman. I want to know whether you reflected what you believed was going on in your hospital to any of those external organisations, and, I guess, yes, you would end up in the press. But, if you did not, what did you do? Did you actually reflect the situation

that the strategic health authority was saying, or how did you handle it?

Gary Walker: All that information has been supplied to you and is in this document, and when you have time to read it I am sure you will see. For example, there is an e-mail on 8 April 2009 that sets out quite a lot of issues. There is an e-mail later in May that was on my agenda with Barbara Hakin, which sets out a lot of those issues.

Q452 Andrew George: But that is internal.

Gary Walker: It is internal. I should be blowing the whistle to the media then, should I? Is that your question?

Q453 Andrew George: No. It is just that the questions would have been raised. The point that I was raising and Rosie is taking up is that, if there were evident failings in the hospital, which I imagine that there would have been by now, by that point in time—

Gary Walker: The whole point about this is that I was trying to run a hospital that was not doing harm. By ignoring all the things that were going on, the pressure on my staff and the pressure on me to go and hit targets, I was trying to do my best to protect patients. I am not waiting until something has gone disastrously wrong to say, “Look, I was right. Look at all those patients who have come to harm.”

Q454 Andrew George: No, but you were at 100% capacity. You are saying that the situation was still safe and there were no questions, you had no casework, no patients and no families coming back and saying, “Why was my father, mother or child treated in the way?”—

Gary Walker: I cannot categorically say that that never happened.

Q455 Andrew George: What explanation can you give?

Gary Walker: I cannot say that that never happened because no hospital in the country could ever say that. But I do not know that there were any specifics that were coming out at that time.

Q456 Rosie Cooper: Did the press not notice you were 100% full? Did the press not notice that you had a problem?

Gary Walker: The media covered red alert quite often.

Q457 Rosie Cooper: What was your statement to them? What did it say?

Gary Walker: I don’t know. I would have to look for the exact words, but it would have been along the lines of—

Q458 Rosie Cooper: It is really important. It goes to the core of this.

Gary Walker: “We are trying to do everything as safely as possible.”

Q459 Rosie Cooper: What did you, as chief exec, authorise your hospital to say in the face of a question

from—we will go now with—the press? When they asked you a question, what did you say?

Gary Walker: It will be what I have always said, which is that the first priority is to manage safety. If you would like me to forward media clippings to you for that period that will say exactly that, I am more than happy to do so.

David Bowles: Can I perhaps try and bring this back and answer two questions? First of all, I can tell you what Mr Walker was saying internally. He was saying, “You do not risk patient safety. You do not make early discharges. You do not put beds where beds should not be.” These are the things that I heard Mr Walker saying to his staff. What he was trying to do, in terms of that tipping point, was to keep it on the right side of safety. I had conversations with Mr Walker about one or two instances where allegations were made that patients had been discharged over-early to create capacity. They had been discharged early because of very dangerously ill patients coming in. So we were at that point—not a Mid Staffordshire point of 1,200 patients dying.

What is more tragic is what happened after Mr Walker left, when you will see the evidence from the clinical director that said, “After Mr Walker left, there was a fundamental shift from safety to giving a priority to targets and a series of letters from consultants alleging that patients came to harm as a result of that fundamental shift that occurred after Mr Walker.” MPs were also briefed by me. Gillian Merron, who was a junior Health Minister, and Mark Simmonds, who was a Conservative health spokesman, were briefed by me.

Q460 Rosie Cooper: Okay. Can I ask you, Mr Bowles, what did you see going out publicly, not what you were talking to each other about? What was the message the public—be it the press, the MPs, complaints or patients—were getting from you?

Gary Walker: Chairman, I think I have answered that question several times. I am happy to supply the media cuttings from that period if it helps.

Q461 Chair: If there are some media cuttings, it would be helpful.

Gary Walker: May I say two more things on the compromise agreement, as we are running out of time and there are a couple of points I need to make? If you turn to page 9 of the compromise agreement, you will see that it is signed by the respondent, which is the trust, and on behalf of “its Associated Persons”. There isn’t time here to go through that, but if you look at the definitions of the contract, “Associated Persons” includes the Department of Health, and they have been added in as a handwritten note on the day. So you will see that the Department of Health was a beneficiary to the gagging order, as was, technically, the entire NHS.

Q462 Valerie Vaz: Can I just ask above “For and on behalf of the Trust” whose is the signature?

Gary Walker: That is Paul Richardson, the chairman.
Valerie Vaz: Richardson. It looked like Nicholson for a minute.

Gary Walker: Of course, when you read the document a bit more fully, you will see that Paul Richardson

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was appointed in an unusual manner because he was appointed by Barbara Hakin.

Can I also ask you to look at appendix 2 quickly? Bearing in mind that I was allegedly sacked for gross misconduct, according to the strategic health authority's briefing to you today, the reason that they are giving is that it was around my performance. Both of those issues are addressed in this agreed reference where it says that I "worked diligently", and it goes on to say that "Notwithstanding what has been reported in the media"—which is that I was sacked for swearing—"we have no hesitation in providing this positive reference." My comment on that is that it cannot be that both are true—that there is a reference there that is saying that I worked diligently and giving me a positive reference if I was also dismissed for those other items.

Could I quickly go on to ask you to read the Care Quality Commission letter that I sent? I have extracted it in my brief at paragraph 103. As you can see, there are details of patients coming to harm. The most significant one there that Mr Bowles has already mentioned is about the clinical director and the shift of safety to targets, but, in item "d" on that, the only help that the trust ever received during that period, despite what the health authority have claimed of sending in support teams and turnaround teams, is that a senior officer from the health authority did go to the trust. During his time at the trust, he advised that the coding of patients should be changed in order to report the delivery of the target; so that is a manipulation of the waiting list. The individual, a board member, objected to and complained about that. He has subsequently left the organisation and has a gag and a pay-off in a similar manner to myself.

Q463 Rosie Cooper: Excuse me, but did you say a board member has had a pay-off?

Gary Walker: A board member has had a pay-off.

Q464 Rosie Cooper: Is that a non-exec board member?

Gary Walker: No, an executive board member.

Q465 Barbara Keeley: You mentioned something about us having time to read this. I was reading this at midnight last night.

Gary Walker: I apologise for that.

Q466 Barbara Keeley: There were hundreds of pages and we had a debate that went on until after midnight last night. This is a very difficult week to have that amount of information and—I am sure I say this on behalf of all colleagues—I think we have done a valiant job to try to get through them.

Gary Walker: I do appreciate that; you have indeed.

Q467 Chair: We are now out of time? Can I ask you to reflect at the end of the session on anything you would like to draw out, not really around the dispute or the way it was handled in the employment tribunal and all that, which is really not, I think, our area of prime concern? What would you like to say to us are the two or three key things that need to be done to address the cultural failure that you have described?

David Bowles: That is a very important question. The difficulty, as I see it, is that we still have an organisation that is in denial. When the chief executive, David Nicholson, personally turns round and says, "Gary Walker is not a whistleblower," when you have that degree of denial within an organisation—he denies the 2008 reports are an accurate reflection of the culture of the NHS—I find that culture wholly inconsistent with safe care. I have included in the information pack—

Q468 Chair: If I can just interrupt you, the area of prime concern to the Committee is that we cannot, in the light of Francis, say the culture is fine. We know that the culture is not fine. The question is how we convert the fine words into culture change.

David Bowles: I do not think you convert the fine words into more sticks by saying, "We will prosecute people who manipulate mortality and waiting list data." Yes, it is wrong, but why have they done it? They have done it out of fear of job loss, looking bad. You have to go to why these people do things, and they do them because of the underlying culture of the organisation. That is what it said in the Mid Staffordshire report. The fear of losing jobs is why they provided sub-optimal care.

So you have to tackle that culture, but the culture is set by the organisation's leaders. There is too much evidence emerging that this was not just Mid Staffordshire, and therefore you have to look at who sets the overarching culture. That is set by people like David Nicholson. I have to say that it is deeply ingrained, and I do not believe that you can change the culture of the NHS without changing its leaders. That is a very difficult question, I know, that has been going round and round. As to more regulation about gagging clauses, yes, it is helpful, but, frankly, if people are still scared about their career implications from speaking up, banning gagging clauses is not going to make any impact at all.

Q469 Chair: There is a great tendency to identify this culture with the personality of the current chief executive, but, as I said in the debate on this subject last week, I was Health Secretary nearly 20 years ago and it was often said at the time that there was a gagging culture—people were nervous about speaking out. I think it runs much deeper than the personality of a single individual, hence my question.

David Bowles: That is a sign of the deep-rooted nature of the problem. I conducted a review at NHS Lothian and I refer to it here. I interviewed people who described to me issues and events that were, frankly, appalling, and they regarded it as normal. The culture of the NHS is so deep-rooted that things that you and I would regard as appalling are just regarded as, "Well, aren't all managers like that?" Unless or until you have major cultural change, with leaders at the top who are genuinely committed to that cultural change, then you are not going to deliver it.

David Nicholson has not intervened personally on one whistleblowing case. Did he try and find out what had happened to Mr Walker at any stage? It has been all over the press. The "Today" programme broadcast the details of a super-gag nine months ago. Did David

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Nicholson personally go along and identify any individual in the NHS who has gagged a person and held them personally to account for doing so? There has been no personal leadership, no responsibility from the top. I have run large organisations as well, and you change them by demonstrating personal behaviours and conducts from the top of the organisation. I see very little sign of that happening, I am afraid, Chairman.

Q470 Chair: Mr Walker, is there anything you want to add?

Gary Walker: I totally agree with that. Gagging of whistleblowers has been going on for many years. In 1999, attempts were made to stop that, and 14 years later we are still getting more. We have found out in the last few weeks that there are 400 compromise agreements, most of which have gagging in them. We do not know how many whistleblowers are in there and we do not know what has been covered up. This use of public money to cover up individual failings is, I think, a major problem. I cannot see for a moment that anybody involved in a compromise deal such as the individual being paid off is actually benefiting because they tend not to work in the health service after that. Certainly, the patients are not benefiting if patient harm is being covered up. So somebody is benefiting by a gagging order and public money is being used for that gain.

On that basis, I think a very serious look needs to be taken at exactly what has been going on with those agreements. Yesterday, another 44 were announced. There are so many gagging orders out there; we just do not know how many there are. We also know that in the last couple of years the Department of Health has changed its own rules, even though the Treasury has not changed its rules, about approval. The Department of Health has changed its own rules and says that judicial mediation does not require Treasury approval. The Treasury thinks it does. So the Department of Health has acted to specifically hide the fact that it is paying off and gagging people, and

that, I think, makes David Nicholson entirely culpable for those things. At the very least, what has he done in six years to improve whistleblowing in the NHS, because, as far as I can see, it is much worse now than it has ever been?

This is a deep-rooted culture, and I am going to use the NHS East Midlands' briefing to you. It says: "National standards are designed to improve patient safety and to enhance the patient experience as a whole. There is no contradiction between achieving these standards"—i.e. the targets—"and improving the safety and quality of care." If Mid Staffordshire did not prove that there was a contradiction between targets and quality, then nothing will prove anything more than that.

I think David Nicholson is accountable for a system. I do not particularly want somebody just to resign like they always do and get a pay-off and walk away. I think the accountability for people at the top must apply in the same way as it would for me if I was chief executive. If people had made allegations that I had misled committees, had lied about things, had conducted bogus reviews from people who were known to conduct bogus reviews, and had used all that public money to gag people, then I would expect to be suspended and investigated until that was dealt with.

One last point I would say is that I have information given to me that was in the bundle that suggests that Dame Barbara was party to, or at least in some way involved in, ensuring that the payment was made to me. Remember, as we have heard, that it is a payment significantly more than an employment tribunal would have awarded on an unfair dismissal claim. If it is the case that Barbara Hakin is responsible for that payment, that makes it a very serious charge, potentially of misconduct, on the basis that you cannot use public money to silence matters of your own misconduct. Thank you.

Chair: I think, at that point, we should draw the meeting to a close. Thank you for your attendance. Thank you very much.

Tuesday 23 April 2013

Members present:

Mr Stephen Dorrell (Chair)

Andrew George
Barbara Keeley
Grahame M. Morris
Andrew Percy

Mr Virendra Sharma
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: **Rt Hon Jeremy Hunt MP**, Secretary of State for Health, and **Una O'Brien CB**, Permanent Secretary, Department of Health, gave evidence.

Q471 Chair: Good afternoon, Secretary of State and Permanent Secretary. You are both very welcome to the Committee. As you know, this is a hearing following on the hearings we have had about the Francis report and the Government's own preliminary response to the Francis report. It would be helpful to the Committee if we can simply begin. I should say at the beginning of this session that we want to cover a lot of ground, so—if I may appeal to my colleagues—if we can keep both questions and answers, in the words of the Speaker, short, we will cover more ground more efficiently.

I would like to begin by asking you to set the scene, Secretary of State, about how the Government intend to take forward their further response to 290 recommendations from this point. You made it clear when you made a statement to the House that this was your initial response and there was further work still to do.

Mr Hunt: Yes. First of all, thank you to the Committee for this opportunity to discuss what I think is, as far as the public are concerned, the single most important issue that they would like to see addressed in the NHS—but there are other broader issues which we may come on to as well. I would describe it as my substantive response. We will go through all 290 recommendations later this year, and essentially we intend to accept the spirit of all of them. We agree with what Robert Francis was basically saying. There may be recommendations where we can achieve the same thing as he wanted in a slightly different way. What we have announced so far covers around 100 of them, but I think there is enough there for people to see the heart of how we intend to give the public confidence that, where there is poor care, it will be rooted out and dealt with more quickly than happened at Mid Staffordshire.

Q472 Chair: May I ask you to be a bit clearer about the thought process that led to the work that Don Berwick is doing? On the face of it, it is odd, Robert Francis having spent four years looking into the background as to what happened in Stafford, now to have another report from Don Berwick. What is the added value in that?

Mr Hunt: Basically what he is doing is giving us information about how to fix the problem that Robert Francis identified, so it is an implementation thing. It will be a quick process. He is going to report in July. The main way that we will implement what he says

is through the new inspection regime that the chief inspector of hospitals will be implementing from the end of this year. That will start, as I say, before the end of this year. So it is really about how you get large-scale culture change across the organisation. What is the test of whether we are getting that organisational change? The latest figures I saw show that inside the NHS in a year there were 70 wrong-site operations, which is pretty shocking. How do you create a culture where that kind of thing doesn't happen? Don says it is a four-year process. I want to make sure we start off in the right direction.

Q473 Chair: The title of the advisory group is Safety of Patients in England, and the terms of reference appear to focus the attention of Don Berwick's work very much on safety, as opposed to the other two principal parameters of quality as it is these days defined.

Mr Hunt: Yes. This is only one part of our response to Francis, but I think it is an important part, because in some of the meetings that I had with the Mid Staffs families, Cure the NHS and people like that, they said that what was missing was what they call a zero-harm culture, in which harm to patients is as rare, or as big a deal, as fatalities in the airline industry, for example. They said they thought that was a very profound cultural change. It is interesting that that has happened in some parts of the NHS already. If you look at the work at Salford Royal, for example, it has an outstandingly good record on safety. The Don Berwick review is going to help us to understand how one rolls that culture out more widely.

Q474 Chair: It is odd, isn't it, to be doing work focused on patient safety so soon after the Government announced the abolition of the National Patient Safety Agency as a separate focus of attention in the monitoring of quality? And perhaps the need for it is illustrated by the recent saga in Leeds as well.

Mr Hunt: We have never wavered in our commitment to safety. The question is how you—to use that horrible phrase—mainstream a commitment to safety throughout the whole NHS. I am very confident that safety will be one of the domains that the chief inspector of hospitals looks at when he or she goes round every hospital in the country. It will be a critical part of the definition of success for a hospital—and also, indeed, beyond the hospital sector.

Q475 Andrew Percy: You have picked up on Leeds, and we have heard the phrase “patient safety” used a lot. As you can imagine, in my constituency and across Yorkshire and northern Lincolnshire we have had the word “safety” bandied about in March regarding the Leeds unit, and it has caused considerable concern to my constituents. So first of all, Secretary of State, could you give us your opinion on the events of March with regard to the Leeds unit, which we now know happened a day or two after a High Court case was lost; we had the use of dodgy data and the unit was blamed. All sorts of allegations were thrown up about whistleblowers, when in fact those whistleblowers happened to come from units that just the day before had lost a case in the courts. Could you give us your views on what, frankly, to me as a local MP and to people who use the unit, has been a pretty despicable process?

Mr Hunt: I would not use those words, but let me say straight up that I completely understand the widespread concern in Leeds and neighbouring areas about the future of the heart surgery unit. I understand and appreciate why this is something that people feel extremely strongly about and, indeed, the distress that this kind of issue causes. But I do think we need to have a different approach to safety issues in the NHS. What happened at Bristol and at Mid Staffs was that there was disturbing data, and then there was a big argument about whether the data was any good, and nothing was done in the period where the data existed. The result was that patients continued to be harmed and 30 to 35 children lost their lives, arguably unnecessarily, in Bristol.

I would never want—and I do not think any of us would want—to be in an NHS where we put patient safety at risk. If there is a potential problem, the responsible thing—the only thing—that Bruce Keogh could have done, faced with the information he had, was to say, “We’re going to get to the bottom of this data. We’re going to find out if it’s right or not—but we’re going to suspend heart surgery while we do that.” That was absolutely the right decision. I was as delighted as he was, and the people of Leeds were, that, on further investigation, it was found that it was safe to continue. It is also important to say that part of the reason for what you describe as the “dodgy data” was that the hospital themselves did not supply correct and complete data. Also, they have made changes that have persuaded everyone in the system that it is safe to continue. They are not continuing in exactly the way that they were operating previously.

Q476 Andrew Percy: Is it not the case, though, that the situation with Mid Staffordshire was incredibly different, because we had five years of data? This is information that was only a few hours old. Indeed, Dr Cunningham, who is one of the senior strategists at NICOR, has clearly said that the conversation on this data was only the first pass, so it was incomplete data and Sir Bruce Keogh should have known, as the person who established this unit, that this was data that did not really stand the test. I cannot believe that we are hearing that this is a process that can be defended, or indeed a model or a process that we would want to see another unit go through. That does

seem strange to those of us in Leeds, particularly when we look at how Bristol was treated in October 2012 when the CQC had ruled that the trust was failing to meet essential standards on quality. There was no heavy-handed approach and suspension there. In November 2012, a coroner found 10 failures over the death of a little girl at Birmingham in 2009. Those units were dealt with differently.

This was dodgy data, and to throw it back at the unit is not acceptable, because this was, as was said by the senior strategist from NICOR, the first pass of the data. I would seek from you, Secretary of State, an assurance that the way Leeds has been treated—which has done huge reputational damage to the unit, not only in the region but nationally, and has caused a huge amount of concern to patients—is not the model that we are going to see used elsewhere in the country. That would then be defended by saying, “Look at Mid Staffs.” But the difference with Mid Staffs was that we had five years of data that should have been picked up on. Here we had data that was only a few hours old, which analysts who are used to dealing with this, including Bruce Keogh, should have known was incomplete information. I want to express to you the concern that this has caused, and seek an assurance that we are not going to see this as a model to be used elsewhere in the country.

Mr Hunt: Perhaps I could ask you how you would do it differently. If a hospital supplies incorrect data and the result is that it shows that their mortality rates are two and three-quarters higher than what might be expected to be the national average, are you really saying that you think the NHS should not take immediate action?

Q477 Andrew Percy: What I would probably say is that we should follow the Healthcare Quality Improvement Partnership steps, which they clearly set out in their process, whereby they would notify the audit team and have additional scrutiny of the data. Statistical analysis would then be undertaken and the “Lead Clinician...within the provider organisation should be contacted about the potential outlier performance,” and asked “to either validate the results, or identify any data errors”. Those are the exact steps that are set out by the Healthcare Quality Improvement Partnership, and they do not appear to have been followed here. We had this strange situation where people just appeared with data that was only a few hours old. The unit was not able to test that robustly, and we then had this heavy-handed approach, which was proven to be unnecessary but which has done huge reputational damage—coming, as well, just a day or two after the High Court decision. I would have thought there would have been a conversation with the unit first, to establish whether or not the data was correct.

Mr Hunt: We have to do all those investigations into the data immediately. The question is whether heart surgery should continue while investigations are being carried out into data that indicates that mortality rates may be two and three-quarter times higher than they should be. Also, let us be clear that this was not the only concern about what was going on there. There were also concerns about the staffing rota. There were

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concerns about the referral of more complex cases. There was—as I think Sir Bruce Keogh described it—a constellation of concerns. The only responsible thing to do in that situation is to suspend surgery. I accept that it is more messy to do it that way, but I would ask you whether you would be able to look in the eye the family of someone who was then operated on unsuccessfully, perhaps with fatal consequences, and say that allowing that surgery to continue was the right thing to do while we investigated whether there was a real problem in the data.

I want to say this: I think that is something that I do want to change throughout the NHS. I want people to take patient safety much more seriously than it has been taken in the past, and I do not want operations to continue where there is a serious concern about safety and risks to patients. That is part of the change that we need to see, and that the public want, in response to what happened at Mid Staffs.

Q478 Chair: Is there not a learning experience coming out of Mid Staffs, Leeds, and indeed out of other examples in the health service, that what is required is a real-time process that does identify data that should give rise to patient safety concerns, but also sifts it as part of an ongoing routine—with, of course, the ability to act and intervene quickly if new data becomes available, but to intervene following proper testing of the data?

Mr Hunt: I agree with you, and I think one of the big changes that we are making at the moment is to make surgery survival rates much more transparent. We are rolling them out now to 10 specialties. It has been incredibly successful for adult heart surgery. It is much harder for children's heart surgery because the actual number of operations is so small. We all need, and the public need, to understand that, where you suspend surgery because there is a concern, it does not mean that there is a problem; it just means you are doing an investigation. We need to understand that the right thing to do, where there may be a problem, is not potentially to put anyone's life at risk by proceeding.

That is a big cultural change, and I fully accept that we need to learn from what happened on this occasion. Indeed, the other thing we need to recognise is that the rate at which that data becomes available is going to be a gradual process over the next few years as more information reaches the public domain and we get the risk adjustment right. So it is going to be a transition for everyone.

Q479 Andrew Percy: I do not really like the attempt to paint those of us who have criticised this process as if we were in some way prepared to be lax and put patients at risk. In Yorkshire, constituents of mine—indeed, from my area—were put at risk because they were moved to other units while this was going on. This is really the point that the Chairman just made—that we are all happy to support a tough decision if it is backed up by evidence and data. The “constellation” point that is referred to has been thrown out there on a number of occasions, but of course the whistleblowing complaints that formed part of that constellation came from another unit, which

had just two days before been a defeated party in court. I don't want us to be painted as in some way merely supporting our unit—we are all aware of our responsibilities, especially now after Francis—but this came down to a situation where data was used that it should have been clear from the very beginning was obviously dodgy. I still cannot get into my head the reason why Leeds was treated so differently from Bristol and Birmingham, which had had similar complaints. There were other units that had outliers in their data, and Leeds was treated differently. That was my final comment, or question.

Mr Hunt: I need to say that we want to treat concerns about mortality data differently everywhere from now on. This is the lesson from Mid Staffs. I do not think you and I are in any disagreement that, where there is a first cut of data, the most important thing is to get to the bottom of whether or not there is a real problem. Where we may disagree is whether, while you are doing that, you take a decision to suspend the surgery that is happening at a particular place. That needs to be an operational decision based on what the actual risks are to patients.

Andrew Percy: We just don't want the Leeds model.

Chair: We cannot have a competition for the last word.

Q480 Valerie Vaz: May I stick with Leeds, because it is important to learn the lessons from that? You know that Stafford hospital is very close to my constituency and certain things have happened there that I do want to ask you about, perhaps a bit later. What I would like to find out now is this: when did Sir Bruce Keogh have this information and when did he tell you about it?

Mr Hunt: I found out about the information on 28 March, the day before it went into the public domain. I was informed; it was not my decision, because this is an operational decision. I was following the advice I had from the NHS medical director as to what was the most appropriate course of action with respect to patient safety in Leeds, but I knew the day before it went into the public domain, and on the day it went into the public domain I spoke to three local MPs.

Q481 Valerie Vaz: When did Sir Bruce Keogh have this information?

Mr Hunt: I believe it was—I think he had the information on the Tuesday of that week. I will write to you if it is different information. I think I was told about it on the Thursday.

Q482 Valerie Vaz: So he had the information while the court case was going on.

Mr Hunt: I think the court case is completely irrelevant to this. Professor Keogh has a responsibility—

Q483 Valerie Vaz: I am just asking: did he have the information when the court case was going on?

Mr Hunt: I don't know the exact dates when the court case was going on.

Q484 Valerie Vaz: Okay, but he had it before he went in and suspended operations at Leeds.

Mr Hunt: There was a short period—

Q485 Valerie Vaz: He had it a while before, did he?

Mr Hunt: I don't know. I will write to you with the exact date that he had it.

Q486 Valerie Vaz: I think that you should know, because you are the Secretary of State and this was a huge issue which made the front pages of lots of newspapers. It is the kind of thing that people feel they have to do—publicise—and then people feel defeated. They don't want to do that. The good thing is that the Leeds clinicians fought back; they were on television, but they looked really tired, and they fought back. My key point is: did Sir Bruce Keogh have the information before, and should he not have published that and told people about it?

Mr Hunt: As I say, I will find out and let you know the exact date he got it, but he took a pretty rapid decision based on his operational belief as to what was the prudent thing to do on the basis that there might be a risk to patient safety. I think he took exactly the right decision.

Q487 Valerie Vaz: That, as well, may be. So he has this data and goes in. When did he verify it with the hospital?

Mr Hunt: He had immediate discussions with the hospital, but the question that caused the controversy was what happened—

Q488 Valerie Vaz: Was it on the day that he suspended it?

Mr Hunt: The decision was taken to get to the bottom of what had happened with the data, and he informed me at the time that this was going to be a matter of weeks, not months. But the difficult decision was whether to carry on with surgery in the meantime. I think he rightly decided that, where there was a possibility of danger to patients, the prudent thing to do was to suspend surgery in the meantime.

Q489 Valerie Vaz: So he did not discuss his version of his data with the hospital. He did not ask them for their data.

Mr Hunt: It was not his—

Q490 Valerie Vaz: Did he say, "My data's correct; your data's wrong. Have you got any data?" This is quite key, isn't it? As you say—and we all agree, and I totally understand, what you are trying to do with transparency—the point about transparency is, "Is all this data publishable?" The plea to come out from here is to make this publishable so that people know what they are talking about. He may have correct data, but did he check it with the appropriate people, and was it the correct data? I thought that was the argument, wasn't it, because they did not have the same data?

Mr Hunt: Let us first of all be clear. It is not "his set of data" and "their set of data".

Q491 Valerie Vaz: It is his decision. He is making the decision, isn't he?

Mr Hunt: The data that we are talking about is the data that was supplied by the hospital, and that was deficient.

Q492 Valerie Vaz: To him?

Mr Hunt: To the system, not specifically to him. That data was deficient in some pretty important details, such as the weight of the children who had operations. That is an important part of the risk adjustment process that you do to decide what excess mortality is. When he was informed about this data it was a first cut of data, so it was right that that kind of data should not be published until you have properly drilled down and got to the bottom of it. Then I agree with you entirely that we do want to have a system where that data is made available to the public much more quickly. That is what we are working towards, and there is a big transparency revolution.

Just as an aside, one of the problems with Mid Staffs was that there were issues that bits of the system knew about but the public did not. That is what we want to avoid. So, yes, we do want that data to be made publicly available as soon as possible.

Q493 Dr Wollaston: Secretary of State, isn't there a wider issue that has been missed here, which goes back to the Bristol heart scandal—the fact that all paediatric cardiac patients are going to be safer if we have a smaller number of larger units? Are we going to be able to get away from this idea about which unit has different mortalities, grasp the nettle and say we need to have a smaller number of units and not have a system where everybody is fighting for their own personal unit? How are you going to drive that forward so as to put the safety of all patients across the whole NHS at the top of the agenda?

Mr Hunt: Trust you to get to the nub of the issue, and that is the substantive issue. I would be delighted to discuss that with you in great detail on another occasion, but because that is what "Safe and Sustainable" is, and "Safe and Sustainable" is subject to legal proceedings at the moment and I have to make a final decision on this, based on what the independent reconfiguration panel says, I will not comment on that with respect to children's heart surgery, if you don't mind. But I can say to you that I accept the clinical case that in a number of areas—I think the best example is what has happened to stroke care in London; London is now the safest place in the country to have a stroke, because they reduced the number of hospitals looking after people with strokes, I think from 32 to 8, and halved the stroke mortality rate in the process—there is a very big body of clinical evidence about that.

Q494 Dr Wollaston: So do we need to change the procedures so that these things can happen more efficiently, and people can understand and be very clear that that is the way we prioritise patient safety?

Mr Hunt: That is one of the reasons why we need to have much more transparency about that data. I think the public do understand that certain, more complex, needs need to be treated in fewer places, where specialist expertise can be developed and they can get the best possible treatment as a result. So I think there

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is that understanding. There is something else, though. Even when you have the right number of places—for example, cancer treatment, rightly, is given in many hospitals across the country—publishing mortality rate variations can be very helpful in identifying outlying practice and where the right procedures are not being followed. We have seen some extraordinary improvements in heart surgery performance after the pioneering work by Ben Bridgewater and Bruce Keogh in publishing heart surgery survival rates. There is a benefit, even if you are not thinking about it in terms of potential consolidation of where surgery happens.

David Tredinnick: I would like to move on to talk about duty of candour.

Q495 Valerie Vaz: Before you move on, Secretary of State, I want to ask you, if it is possible—I know there is lots of different information coming out, but it would be very helpful if you could do this—for the public generally, either to write to the Committee or put on your website a timeline of who knew what and when in terms of Leeds? That would help us to move forward, and help with how to handle future situations.

Mr Hunt: I am more than happy to do so.

Valerie Vaz: Thank you.

Q496 David Tredinnick: You have accepted the Francis recommendation for a statutory duty of candour to apply in cases where hospital errors have led to the death or serious injury of a patient. As I understand it, this duty is to sit alongside an existing contractual duty of candour in standard contracts between commissioners and providers to be “open and honest with patients when things go wrong”. What penalties are there for providers if they breach the contractual duty of candour they have with commissioners?

Mr Hunt: That is something that we will be coming to in due course, but it depends on whether the responsibility lies with an individual or an organisation. The point is that we think that providers should have a duty in law to be transparent with people when they have done harm, and we accept that. What we have said that we are going to wait to decide is whether individuals should have criminal responsibility for breaching that statutory duty of candour. That is one of the things that Robert Francis has asked us to consider. The reason why we are not announcing our decision on that at this stage is because we want to wait for the Don Berwick safety review.

The most important thing in all of this is to create a culture of openness, in which where there are mistakes they are admitted, and patients and families know as quickly as possible. We want to make sure that there are not any negative consequences in terms of the worry people have, because you might in fact end up with a culture of fear where, if someone has done the wrong thing and a colleague talks about it, there is the potential for a criminal investigation. We gave our initial response very quickly because we wanted to get cracking, but that was an area where we did not want to rush in and to make a wrong decision.

Q497 David Tredinnick: It is work in progress. There is work to be done on this.

Mr Hunt: Correct.

Q498 Barbara Keeley: May I ask an additional question on the definitions around where hospital errors have led to death or serious injury to a patient? It strikes me that there is also the issue of where a relative, as a patient, has died in very bad circumstances. So the care didn't lead to harm in the sense of a death or injury—maybe the person was going to die at some point anyway—but it comes through clearly from the Francis report how many families were distressed because of the way that their relative died. As we are concerned about palliative care, that is an important thing too. If they feel guilty about the way that their mother, father or sibling died, that is a harm that people, in my experience, do not get over.

Mr Hunt: I completely agree with that. Let me be clear that just because someone might have died within a few weeks or months anyway, it does not mean that a hospital would not, under the statutory duty of candour, have an obligation to tell family if they thought they were responsible, because of poor care, for that death happening earlier than it might have happened. There is no get-out in that respect at all.

I also want to make the point that we want there to be openness and candour where there is any type of harm. So it is not just about where there is serious injury or death. But when you are talking about statutory duties backed by laws passed in this place, you do have to be careful. As I say, what we are trying to do is to get this tricky balance right so that we do not over-legislate and make the overriding concern in hospitals one about people protecting their legal backsides. We want people to feel that where there is harm, where things go wrong, the normal and right course of action is to be open with everyone about it.

Q499 David Tredinnick: Following on from Barbara's question, do you accept that relatives should have a remedy where hospitals have breached a statutory duty of candour?

Mr Hunt: They will. That is what a statutory duty of candour is. They will have recourse under the law. The hospital will have broken the law.

Q500 David Tredinnick: What form should that remedy take, over and above compliance with the duty?

Mr Hunt: We have said we accept that there will be legal recourse—that it will be against the law—but precisely what the penalties will be is something we are looking into at the moment.

Q501 David Tredinnick: Finally on this, it seems that you are proposing two duties of candour. On the one hand you have a contractual one, and then you have a statutory one as well. Doesn't this risk causing a lot of confusion among providers and the public?

Mr Hunt: No. Contractual duty of candour applies to everything; it is a standard part of all NHS contracts. What it is saying to people working inside the NHS

is, “It is your contractual responsibility as part of working at this hospital”—or in this NHS establishment—“that if you are responsible for patient harm, or if you see patient harm, you tell someone about it.” That is part of people’s contracts. What we are saying is that there will be a statutory duty on organisations to make sure that people who are harmed, or their families, are told, where this has led to serious harm or death. It is a higher grade, if you like, for the organisation. We have also said that there will be criminal liability on organisations if they deliberately supply misleading information about things like mortality rates. We are raising the bar in terms of the potential sanctions at organisation level, but we are going to wait until Don Berwick completes his review before we decide whether that should apply to people at an individual level as well.

Q502 Chair: If there is already a contractual duty of candour and there is somebody, in the form of a commissioner, who has a duty to enforce the contractual duty of candour, why do you think it would be any more effective to have what would effectively be a duty at large to be candid?

Mr Hunt: Because we have had the contractual duty of candour for some time, and we are trying to send a signal that this really matters, that this is a board-level responsibility on providers. We want it to be absolutely clear to them that this is a legal responsibility.

Q503 Chair: Who enforces it?

Mr Hunt: The board will be legally liable. Families—

Q504 Chair: If the board has failed?

Mr Hunt: If the board failed, the family could take—

Q505 Chair: But how do the families find out if someone has not been candid?

Mr Hunt: That is what we are trying to change. We are trying to make it much easier for them to find out. We are trying to change the culture when it comes to whistleblowing, for example, so that it is not possible for whistleblowers to be suppressed as has happened in the past. If I may say so, Chairman, that is precisely the reason why we are hesitating before introducing criminal responsibility at every level of an organisation. We do not want large-scale cover-ups. We want a culture where NHS employees do come forward if they know something has gone wrong.

Q506 Barbara Keeley: I would like to move on to staffing levels, because resources are a key issue in the Francis report, particularly the issue of adequate staffing levels, and publication of those. I have raised with you here in this place issues about that, and there are polls and surveys which seem to indicate concern. Nurse managers, for instance, in a recent poll expressed concern about unsafe staffing levels on three quarters of hospital wards, and one third report staffing levels that are unsafe on a weekly basis. Some say that that can be the case on every single shift. As a member of this Committee, I get people who tweet me. A nurse in the NHS was telling me, via Twitter, that the ratio she was having to work with was 2:29.

It is very disturbing if that is happening, and she persists in telling me that that goes on at her hospital; I don’t know which hospital it is.

Francis recommendation 93 says, “The NHS Litigation Authority should introduce requirements...in relation to staffing levels”. Francis also recommends that “The procedures and metrics produced by NICE should include evidence-based tools for establishing the staffing needs of each service.” You mentioned—I am sure they will be delighted—that Salford Royal as a very safe hospital. I know that they pay very great attention to this issue and they think it is very important that there is transparency. Why can we not have a recommendation to say both that these levels have to be established and that they have to be known? If nurses are very concerned about this—nurse managers are very concerned about it and people are tweeting members of this Committee telling us that it is 2:29 in their hospital—and yet we have very good safe hospitals like Salford that take it as read that all this information should be in the public domain, why not just recommend that the information should be put out there in the public domain by every hospital every day? Let the public decide if they think 2:29 is adequate—and of course they will not think it is adequate.

Mr Hunt: First of all, we are accepting that recommendation by Robert Francis. What we are not doing is saying that we are going to mandate from the centre. Indeed, I think Robert Francis told this Committee that he did not think it would be right for a Secretary of State or Minister to mandate staffing levels.

Q507 Barbara Keeley: But he did say, “The procedures and metrics produced by NICE should include evidence-based tools for establishing the staffing needs of each service.” That is what good hospitals do.

Mr Hunt: I agree. That is what we agree with, and I accept that recommendation. What is interesting at Salford Royal is that they have a tool that changes on a daily basis. If an additional three frail elderly patients are admitted to a ward, that changes the requirement that day on a particular ward and they are able to react, whereas other hospitals do not check their staffing levels except periodically, maybe even only every few months. That very much is best practice, and that is what we want to see happening. The way that we will make sure that it happens is by having every hospital in the country inspected against that standard. So we will look at whether they have adequate staffing.

Q508 Barbara Keeley: But will it not fall off in between? Inspections cannot be every week, can they? You are saying that this is not checked enough—that it is not checked in the way that Salford check it, every day, or changed according to patient needs. I do not know how often inspections will take place, but one hospital could let it drift miles away from where it should be, and then we could be in a situation with two nurses to 29 patients, which is not acceptable.

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Mr Hunt: That is why we will have the inspections, but we will also have a lot of data that is available much more frequently than just when an inspection happens, on things like mortality rates. Also there will be lots of other data on a hospital-by-hospital basis, as we have now, but much greater than the current level. I will certainly look into whether staffing levels are one of the things that should be included in what is published.

Q509 Barbara Keeley: There is no better way than just having each hospital publish it.

Una O'Brien: I completely agree with the Secretary of State. The essence of this is timely transparent data. We need to make sure that the tools are fit for purpose. There needs to be more work on the quality of evidence behind the tools. The second stage is to ensure that they are systematically adopted and, thirdly, that there is adjustment and management on a daily basis. I know from my own experience of working in a hospital just how things can change within a shift. That is a really tough thing to get right systematically across every ward, across every hospital, but it is an ambition that we must have. The critical thing we need is the Salford Royal example, where data is visible on a daily basis to patients and visitors—and that must be the goal that we set ourselves.

Q510 Barbara Keeley: If they can do it, everyone can do it.

Una O'Brien: That is exactly the point.

Q511 Andrew George: Following on from there, Secretary of State, if you are saying that you agree with Robert Francis that these levels should not be mandated from the centre, can we perhaps go down one notch, as it were, and say, “Look, let’s not go for mandatory; let’s go for guidance levels on hospital wards”? If we are to have these tools and the transparency available and, let us say, the information is published, how are we to then judge and assess? Would you not agree that if you are going to have these tools—all this data is being published but no one actually has any kind of guidance or benchmark against which they are then going to judge it—it should be no to mandatory but yes to guidance levels of registered nurses on hospital wards?

Mr Hunt: When I say no to mandatory I am saying no to me mandating it. The problem is that if it is done by a Minister, it is a very blunt tool: “This is the number of patients you have. This is the mandatory ratio of nurses to patients and healthcare assistants to patients.” Also there is a danger, I think, if you do that, that a hospital could think that that is the end of the story as long as they are meeting what the Minister says about the number of nurses. Numbers matter, but nurse training also matters, as does the attitude of the people in the hospital. The investment in technology matters, too, because that will have a big impact on whether nurses spend a lot of time filling out paperwork or whether they can spend time with patients. So there are a lot of other factors. What that Robert Francis recommendation says is that every hospital should have a proper tool that is able to guide

it accurately as to the number of staff needed. That is what we are talking to NICE about at the moment. Then we will be inspecting them against the use of that tool. As Barbara said, that happens on a daily basis in our best hospitals and that is the kind of practice that we would like to see spread out.

I have one final point. I think that the measure of this—and it is very important, if hospitals are going to succeed, that we do not start telling them how to run their internal processes—is how well patients are looked after. One of the key things that the chief inspector will be looking at is the patient experience—things like whether people say they would want their friends or family to be treated there, how the complaints procedure works, patient safety, all those kinds of things, and whether staff would want to treat their own family in their own hospital. Those are very good early-warning systems if people are getting their staffing levels wrong.

Q512 Andrew George: That is helpful. The message that we have had from your chief nursing officer and from others—the mantra coming from the Department, if you do not mind me using that expression—is that it is not about staffing levels; it is about culture and leadership. If I were to give you a single transferrable vote option and to offer you staffing levels, leadership and culture, which order would you place them in?

Valerie Vaz: It’s a Lib Dem proposal.

Andrew George: Joking aside.

Mr Hunt: My predecessor would shoot me if he thought that any mantras were coming from the Department of Health after the Health and Social Care Act.

Andrew George: Put that word aside, then.

Mr Hunt: Let me answer your question—and this is going to sound like a terrible fudge but it really is not. If you read the Francis report and what went wrong at Mid Staffs, it is clear that it is all of those things. It is clear that they skimmed on staff—and that was a terrible thing to do—and that they cut corners. They were trying to get rid of their deficit in order to get foundation trust status. It is clear that the leadership was utterly appalling. What was your third one?

Q513 Andrew George: Culture.

Mr Hunt: It is clear that the culture was completely wrong. That is why when we designed the new inspection regime I was very keen that it should not just look at a single measure. What people are concerned about at the moment is patient care, compassionate care and patient experience, but it is important that this new regime looks at what a hospital needs to do holistically. So it looks at all these different things—culture, leadership, numbers, safety, clinical outcomes—and comes to a holistic view of what a hospital is there to do. In that way we can avoid what I think happened before: there was a big national focus—much needed—on bringing down waiting times, but in some hospitals, particularly where there was weak or bad leadership, that happened to the exclusion of other important things. As a result, you got a very warped outcome.

Q514 Andrew George: Yes, I do think it was a fudge, but nevertheless I respect the response. You are saying that mandatory staffing levels are not a route down which you would be prepared to go. Given that in fact there are mandatory levels in paediatrics and intensive care, do you think that is something that should be done away with?

Mr Hunt: We should follow clinical evidence on these things. If clinical best practice says we need to have a certain staffing level, that is what we should have. What I am nervous about is Ministers dictating that, because very often these things change on a daily basis, certainly in terms of the pressures on something like an ICU.

Q515 Andrew George: I do not think anyone is suggesting that it should be politically rather than clinically inspired.

Mr Hunt: That is a great relief, I am sure, to the 3 million people who use the NHS every week.

Q516 Andrew George: Moving on to your statement to the House on 26 March, and the announcement that you would make it a prerequisite for NHS-funded student nurses to spend up to a year working on the front line as healthcare support workers, you went on to say, "That will ensure that people who become nurses have the right values and understand their role." Is it only nurses that you need to ensure have the right values, or is it doctors, managers, Secretaries of State and others? Are there others who we can ensure have the right values only by making them work as healthcare support workers first, before they are allowed to perform their professional function?

Mr Hunt: If you are suggesting that everyone who wants to be Secretary of State for Health should work as a healthcare assistant, actually I do think that everyone involved in health policy should get experience on the front line. I have been trying to go out on the front line every week over the last month, and I have learned a huge amount from doing it. That is not just the royal visit of the Health Secretary arriving in the hospital, but actually rolling up your sleeves and getting involved in front-line work. I think it is an incredibly important thing to do. Una is putting in place a plan for all Department of Health civil servants to do the same. It is very important, and I would say that it absolutely applies to every part of the health service, including managers.

With regard to nursing, it is very important to say that the vast majority of nurses do an absolutely brilliant job, but we do need to make sure that people go into nursing with the right values. What Health Education England says is that there is a big drop-off, which costs the NHS a lot of money, when people start to do practical experience in the wards as part of their nursing degree. It therefore thinks it would be much better if people had this experience first and could then really see whether they were right for nursing before being accepted for a place on a nursing degree—a place that someone else could have taken—when in fact it was not right for them.

Q517 Andrew George: So this is a mandatory stipulation coming from the centre. I just wanted to

be clear that, if you are going to do this, you are in effect saying that nurses are uniquely, if you like, guilty of not coming to their role with the right values, because it appears to me that you have picked on that profession.

Mr Hunt: Not at all. If you look at that response, you will see that we propose different measures for all the people who are involved in different parts of the NHS. There was a widespread view that there are some issues with nursing that came out in the Francis report that need to be sorted out, but we have also proposed some pretty important changes for healthcare assistants, for managers, for civil servants and for politicians.

Q518 Barbara Keeley: Why did you change the period from three months to a year, though? That seems to be a key point.

Mr Hunt: I don't think it is that big a change. He said "at least three months" and we have said "up to a year".

Q519 Barbara Keeley: But nurses seem to think it is a year. You have had quite a kick-back against it, haven't you?

Mr Hunt: From some nursing leaders. There is also a great deal of support for it in parts of the nursing profession, particularly among some older nurses, who recognise this as being quite similar to how nurse training used to be.

Q520 Andrew George: It is nurse preceptorships, which were, if you like, a casualty of Project 2000. In a sense, being a nurse preceptor is quite a different role, though, isn't it, to working as a healthcare assistant? Is that not the reintroduction of nurse preceptorships for students? Indeed, for postgraduates, provided they were properly paid, that might be an option that you would be prepared to support, particularly if they were supernumerary.

Una O'Brien: We certainly need to look at the practicalities of this, which is why we have been very clear with Health Education England that the first step is to pilot it, because there are different perspectives that need to be tested in order to make it work. The one point that I think is perhaps worth drawing and adding to what the Secretary of State has just said is this. While it is true that we have to recruit for values across the piece for all professions, in the end it is the nurses who coach, train and line manage healthcare assistants on the ward. So they are in a unique relationship to that part of the work force. That provides a linkage between what the aspirant trainee nurse does and the actual outcome of how good they are in that supervisory role at the end of it. One of the lessons from the Francis report is the sense of a disconnect between the role of the healthcare assistant and the role of the qualified nurse; that was never intended by policy but it actually turned out to be the case in practice. What we want to see now is a much broader continuum drawn between those two very important professional roles.

Q521 Andrew George: We do not have time to move on to the practicalities of who employs, who pays and

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so on—perhaps we might later—because I am being urged to move on, which I will. Perhaps we might seek a written note on that, if I may be so bold as to ask.

Coming on to the issue of whistleblowing—certainly the welcome indication that the Government will be responding to the Francis proposals, particularly to enhance the protection for whistleblowers—and moving on from the last set of questions in a sense, if you are whistleblowing to the public or the press you then perhaps get the protective blanket of enhanced protection. In fact what we need to ensure is a culture of proper reporting of inadequate staffing levels—a very strong theme that clearly comes through the Mid Staffs report—and that members of staff are protected and their concerns are respected, and not dismissed in the way that the Mid Staffs example showed. This is pre-whistleblowing in a sense. What can you say will protect members of staff who raise these issues so that they will not have their professionalism undermined as a result of doing so?

Mr Hunt: You are absolutely right. In a way, if you have whistleblowing, the system has failed, because you have reached a point where something has gone seriously wrong and someone thinks their only option is to tell the press or write to someone outside the organisation. We are trying to create a culture where when things go wrong—things go wrong in all large organisations, indeed in all organisations—they are dealt with immediately. The best example of where we would like to see real change is in the way that hospital complaints procedures work. That is a living, breathing way of hospitals finding out how things may not be going the way that they should.

The real change we need there is to make sure that all hospitals do what many hospitals do already, and use the complaints procedure as a way to drive change in behaviour. That is why the work that Ann Clwyd and Tricia Hart are doing is so important. Most of the time, the people who are complaining want just one thing: they want to know that the NHS has learned from the mistake that they experienced. So it is about that cultural change. That is why one of the things that the chief inspector will be looking at when he or she goes round hospitals is the culture in hospitals. One of the questions that all staff are asked in NHS hospitals is whether they feel able to speak out if they see things going wrong with respect to patient care. There is a metric there, but we have to be careful not to overemphasise metrics. We also have to allow inspectors to smell the atmosphere in a hospital and actually decide whether they feel the culture is right. It is a big change. I think we can get there, though.

Q522 Chair: Do you agree with the proposition that it is one thing to go and ask a member of staff whether they feel able to raise concerns, but that a rather more tangible version of the same question is for an inspector on a visit to a hospital to ask to be shown the evidence of when concerns have been raised? If you have a hospital department where no concern has been raised about an untoward event for a whole 12-month period, that probably tells you something about the culture in the department, doesn't it?

Mr Hunt: I would go even further, Mr Chairman, and say that the inspector should ask for evidence as to what has changed in the hospital's procedures and behaviour as a result of complaints from the public. That is the real evidence that there is a listening, open culture.

Q523 Grahame M. Morris: My question is on the same theme, Secretary of State, regarding this culture of openness and candour. You said that, if we are talking about whistleblowers, the system has failed. You reminded us that you had written to all the NHS trusts to tell them about their obligations about public interest disclosures and to ensure that any confidentiality clauses in agreements with former employees embraced the spirit of the guidance that you had issued. Does that guidance negate the need for gagging clauses now? I am rather alarmed, when colleagues are raising issues about staffing levels, that you say, "I'm the Secretary of State now. That's devolved, and I can only give guidance." Most people would think that it is not rocket science, in the care of the elderly, to come up with a number for the staffing ratio and then staff can judge, "This is an issue and we should be raising it as a concern." I am wondering whether it applies here in relation to gagging clauses as well.

Mr Hunt: The Secretary of State has the ability to issue fiats, commands—and mantras even, Mr George—in any range of areas, but the question is where it is appropriate to do so. When it comes to something like staffing numbers, which can change on a day-to-day and a ward-by-ward basis, what is much more important than the Secretary of State deciding what those staffing numbers should be is to have a standard based on a proper tool. That is what we are working on with NICE, to see how that could be developed so that staffing numbers properly reflect the pressures on a ward at any particular hour. That is the critical thing. There are some things that happen NHS-wide. One of them is some of the contracts that are used, and one of the clauses that has typically been in some of the compromise agreements when NHS staff have left the employment of the NHS has been a clause that prevents them from speaking out. If agreements are over a certain value, they have to be approved centrally—not by the Department of Health, but by the Treasury—and we have made it clear that we will not approve any of those contracts unless they explicitly say that people will be free to continue to speak out on matters of patient safety.

Q524 Grahame M. Morris: Does that mean, Secretary of State, if I could press you on that, that there really should not be any need for gagging clauses, and that any contracts that have already been signed with gagging clauses simply do not apply, so you would encourage people who had concerns as whistleblowers—or whatever we wish to call them—to speak out?

Mr Hunt: Yes.

Q525 Grahame M. Morris: That is very definite and I appreciate that. May I ask you another question on the same kind of subject in relation to fairness and

transparency? Do you think that freedom of information requests should also apply to private sector health companies who are providers within the NHS?

Mr Hunt: I think private sector health companies should operate on a level playing field with public sector providers in the system. Certainly, when it comes to transparency, that should apply as well. My particular concern would be things like survival rates, mortality rates and the success rates of different surgical operations. But my basic principle in this would be a level playing field.

Q526 Grahame M. Morris: It is possible for private sector companies who are bidding for public sector work in the health service in particular to disaggregate a contract in terms of FOIs. One of the big elements, of course, is staffing levels, and it is not possible to do that with a private sector provider. Would you agree that that should be addressed and do you intend to do it?

Mr Hunt: Clinical commissioning groups have a responsibility to commission in the best interests of patients, so I would expect them in their commissioning to make sure that any contracts they signed were with organisations that had the right staffing levels. That is an absolutely fundamental point. Clinical commissioning groups are led by GPs, so they would not want it any different.

Una O'Brien: Perhaps it is worth adding that, of course, any organisation—whether third sector or private sector—that is providing health services has to be registered with the CQC and is subject to the CQC inspection regime. The combination of inspection and contract are the two critical levers to drive transparency in non-NHS providers.

Q527 Grahame M. Morris: There is a better way to do it. There is an instruction that could be given by the Secretary of State to say it would apply. Is it correct that Monitor is recommending that? May I take issue with the Secretary of State's answer that clinical commissioning groups would not compromise numbers? Perhaps there is a potential that they might if they have a financial interest in so doing, if they derived a greater return. You are suggesting that is inconceivable. I think it is conceivable.

Mr Hunt: If I may come in here, what the Permanent Secretary is saying is that you have a double lock on private sector providers, not only in terms of the way they are commissioned—CCGs will be commissioning in patients' interests—but also because they will be subject to the same inspection regime. With regard to conflicts, let us be absolutely clear. The CCGs have to publish—we have put this in primary legislation, which was not the case before—any potential conflicts of interest to make sure that there are no doctors who are making decisions in areas that could benefit them financially. Again, that transparency is going to work in terms of making sure that CCGs do act in the interests of the people that they are commissioning care for, and not in their personal financial interests.

Chair: Predictably, this is arousing some interest.

Q528 Barbara Keeley: May I take you back to what you said about gagging clauses, Secretary of State? You talked about the checking being related to the process of Treasury sign-off. But when we talked about this in the case of the United Lincolnshire Hospitals Trust, which we did a few weeks ago, David Nicholson told us—he had told us previously—that there was no Treasury sign-off. That is one of the most shocking things about that really quite large amount of money. There was no Treasury sign-off because there is a loophole if the arrangement relates to an employment tribunal, as it did in that case. You would have no mechanism at ministerial level if there were another such case. It does seem, particularly in the case of that one, which was quite large, that we should not have loopholes like that, should we?

Una O'Brien: Very simply, we have closed the loophole.

Q529 Barbara Keeley: How have you done that?

Una O'Brien: The Treasury guidance has been changed since this came to light.

Q530 Barbara Keeley: Whatever the status, judicial or otherwise.

Una O'Brien: Yes. It has to have the same level of approval.

Q531 Dr Wollaston: Does this indicate that it is sometimes difficult to hold private providers to account for sticking to their contract if you cannot see the full details of the contract and the financial background to it, particularly where halfway through, perhaps, it is found not to be viable and the terms are changed? Do you think it is reasonable for the public to be able to see and hold these companies to account properly by seeing all the details?

Mr Hunt: They should absolutely be held to account. As I say, we should have a level playing field in that respect. We also want to encourage innovation, but I do not think private companies should have anything to fear from transparency in what they do.

Q532 Dr Wollaston: Would you say that they should be subject to FOIs—that they should have to put in all the details? As I say, it is about having transparency and having that army of armchair accountants looking at what is happening and holding them to account. What would be the argument against publishing?

Mr Hunt: We have to have a fair playing field. That is the crucial thing. As for what actually happens, this is something that, as you know, Monitor has been looking at in quite a lot of detail, and there are some things that are easier for private companies and independent sector organisations, and some that are easier for NHS organisations, across a whole range of things. But when it comes to transparency in a way that impacts on patient safety, it needs to apply across the board. When it comes to inspection regimes and CQC licensing, those are issues that override that and need to apply to everyone.

Q533 Andrew George: I have a brief question going back to gagging clauses. Last year we produced a

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report on the CQC in which we raised, among a number of issues, the treatment of Kay Sheldon. Given that reappointments are in the process of being determined, in relation to that and to ensuring that an organisation internally follows the practice that you are advising, will you be taking an overview on ensuring that those who have blown the whistle on an organisation, like Kay Sheldon within the CQC, will not have their reappointment compromised as a result of any internal ill feeling which may still exist?

Mr Hunt: I do want to make sure that people's own future is not compromised if they whistleblow about something that they are concerned about. In this particular case there is a long-running history of acrimony between Kay Sheldon and the CQC board. I am going to be meeting her, so I will withhold any judgment about the individual case until I have had that meeting. What I would say is that I think the CQC itself has changed very dramatically in the last few months since the appointment of David Prior and David Behan and there is a real determination to embrace a new role—to be, if you like, the nation's whistleblower-in-chief, and to root out failure without fear or favour. I think they are really rising to that challenge. So, when I read things in the press about CQC failure, I think it is important to put it in the context of an organisation that is going through very significant improvement.

Q534 Mr Sharma: My question is regarding patient feedback. The report indicates that there was a very low response, or patients were not responding or giving feedback, but that whatever feedback was given was late; data was not collected in time. Now there is a further response from the Government about improving the performance and getting more response, about whether it could be friends and families responding, and how we get it. My question is: how good will the "friends and family" test be as a genuine measure of patient feedback?

Mr Hunt: The answer is that it is an important measure. I think it is already making a difference. It is being rolled out across the NHS from this month for in-patients and A and E, and from September for maternity. It is an important thing to do, but it is also important to say that it is only one measure. It is really important that we do not hang our hat on absolutely everything to do with patient experience being about friends and family. It is very significant that we are asking the question. The staff "friends and family" test is even more significant, asking staff whether they would want their own friends or family to be treated in their own hospital. It is pretty shocking that there are five hospitals where a quarter or more of staff would not want their own friends or family to be treated in their hospital. But I think it is important that these are judgments made in the round, which is why one of the key areas that the new chief inspector of hospitals will be looking at will be the patient experience. They will look at "friends and family" and the complaints procedure. They will talk to people and make an overall judgment about patient experience. I think it is important in that context.

Q535 Mr Sharma: Do you say that action will be taken against providers who have low ratings on the test? What action would be appropriate?

Mr Hunt: There are two types of low ratings. There are low ratings in the context of a breach of what Robert Francis called "fundamental standards", such as patients not being fed or washed properly, not being given water or not being given the right medicines. In that situation the new system is designed to create a failure regime which makes it impossible for the system not to sort out the problem. There will be a time-limited period within which any of those breaches have to be sorted out, and if they are not, the hospital will go into administration. So there is that type of event. Then there is another situation where a hospital gets a low score but is not in breach of fundamental standards, and it needs to improve. That would be very similar to schools that get a disappointing Ofsted report. What you hope is that publishing the fact that things are not well creates pressure on the board to improve. That is one of the exciting changes that have happened in the state education system—that most schools do see themselves on a journey where they are trying to raise standards. Whatever they got from Ofsted, they are trying to do better next time. I hope that is what will happen with the majority of NHS hospitals.

Q536 Valerie Vaz: Have you ever been into a school where they got a low Ofsted and seen the morale of the teachers and students? Sometimes it is not very helpful, is it?

Mr Hunt: Actually, I would disagree with that. I think where you have a poor—

Q537 Valerie Vaz: You have not been a teacher, though, have you, so—

Mr Hunt: I have been into schools that have had disappointing Ofsteds, yes.

Q538 Valerie Vaz: You haven't been a teacher, though, or a pupil who—

Mr Hunt: Yes, but I am perfectly aware that morale is low in schools that are given a bad Ofsted, but the question is: do you want to expose that problem, deal with it and address it, or do you try and pretend that problem is not there? I think the right thing to do is to address that problem—[*Interruption*—as other problems are being addressed as we speak.

Valerie Vaz: Are you trying to escape?

Q539 Grahame M. Morris: Very quickly, I wonder if I could ask you the "family and friends" question, Secretary of State—not that you are either family or friend—but just in terms of not only whether you would recommend the service but whether you and your family actually use it. I am intrigued to know.

Mr Hunt: Are you talking about the NHS?

Q540 Grahame M. Morris: Yes.

Mr Hunt: Yes. Both my children were born on the NHS and I had an operation on the NHS last year, so yes, absolutely. Indeed, I would recommend the service that I received warmly. I thought it was absolutely excellent.

Q541 Dr Wollaston: Moving on to the response to complaints, one of the issues that we found in our inquiry was that many complainants felt they were treated as the problem rather than the issue that they were complaining about. This has been talked about in the NHS for a long time. What do you see as the real change that would make that culture change happen?

Mr Hunt: This was brought alive to me in a conversation I had with Professor Don Berwick, who is doing the safety review. He talked about the performance of hospitals with regard to safety as being on a classic bell curve, where there are some outstanding performers and some terrible performers, with the majority being somewhere in the middle. He said that the most important thing when it came to patient safety was for there to be a learning atmosphere, so that wherever you came on that curve you felt you were on some kind of journey. This is a slightly oblique answer, but we need a system that treats differently organisations where, although they may be in a bad place on the curve, there is a dynamic management determined to address those problems, and places where that management is not in place and they need some root-and-branch changes. For me, that is where a complaints system is so important. Well-run organisations, not just in the NHS but anywhere, really value their complaints procedure because that is a way of finding out what they are doing well and what they are not doing well. It is the impact it has on your daily operations—how much you use it to learn—that is the key thing.

Q542 Dr Wollaston: So that is what you will be using as the marker—how much they are using it to learn—and different institutions will be at a different place and need more intensive change.

Mr Hunt: Yes. I want to be careful, because we will be going out over the summer for proper public consultation about how the inspection regime will work, and that is one of the things that we will be asking people about. But, if you ask me what I have concluded about how complaints procedures need to work, it is that.

Q543 Chair: One of the things that came out of the Francis report was his concept of fundamental standards. This reflects a debate we had with the previous management of CQC—whether CQC is there to regulate to a basic level or to facilitate improvement to the aspirational level. Out of that discussion came a difficulty with focusing on fundamental standards as Robert Francis appears to see them. How do you see that debate? Are you confident that it is possible to deliver a definition of a fundamental standard that does not sound minimalist and tolerant of poor quality?

Mr Hunt: It is a very important question, and I would say that is probably the big change that the Government's response to the Francis report heralds. We do believe that the CQC needs to be there to drive improvement across the system and not just to monitor breaches in fundamental standards. When I read Francis and reflected on my own experience in the last few months it was clear that there is a huge

amount of regulatory complexity, and with the system as it currently stands, it is very hard to work out precisely which organisation is responsible for what. That was one of the big problems with Mid Staffs as well. So we concluded, after a lot of discussions, that it was very important that across the system you have one definition of success for what a hospital should be, that one organisation should be responsible for making that judgment, and that that organisation therefore needs to be responsible, first for checking whether there have been breaches of fundamental standards, but also where on that bell curve a hospital sits in terms of overall performance.

That is why we decided to adopt the model that we have with the CQC. It also means, incidentally, removing from the CQC a very important responsibility—the responsibility it currently has to be part of the solution. We have removed the ability for the CQC to issue enforcement powers. That will be going to Monitor, because we do not want the CQC to be conflicted where there is a problem. We want the CQC to be the people who say, “Yes, this hospital does meet its fundamental standards,” or, “No, it does not.” Then it is other people's responsibility—NHS England, Monitor and so on—to put the problem right.

Q544 Chair: Its role is described as that of a regulator, but it is more of a measuring device.

Mr Hunt: I think the CQC are the people who will drive higher standards throughout the NHS and also be the—

Q545 Chair: That rather leaves open the question: what is the role of the Commissioning Board?

Mr Hunt: They are the independent judge. The Commissioning Board has a huge role in driving up those standards through its oversight of the CCGs, through the contractual commissioning arrangements. But in the end you need a referee, an independent judge, as to whether those standards have been reached or not. That will be the job of the chief inspector of hospitals.

Una O'Brien: I think it is fair to say that we would accept the Francis recommendations on the distinction between the fundamental standards, on the one hand, and, on the other, the standards to push at the boundary of excellence, which NICE will continue to set. We have now established a very clear programme for those standards working through individual specialties. The way that we now envisage the system working will include the ratings system. The basis on which those ratings are achieved will involve NHS England, the CQC and NICE, so that there is one version of what good looks like, not four or five different versions. So it is very important that the standards are really clear.

One of the great lessons that we have learned is that the generic way in which the essential standards were crafted in the 2008 legislation was not fit for what we wanted to achieve. Particularly listening to Robert Francis when he gave evidence to your Committee, I thought that the way he described what fundamental standards should be like, and said that they should be meaningful and visible to the patient or the visitor on

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a ward, was very compelling. It is going to be a challenge to get it right, but I think there is a huge commitment now to do that work over the summer, to consult on it. We need lots of participation from patient groups and third sector and other organisations to help us develop standards that are meaningful, measurable and comprehensible to people on a daily basis on the wards, not some vague generality. That is what's got to change.

Q546 Valerie Vaz: May I turn now to the chief inspector? We want to drill down into that, because you don't seem to like the Health Committee, or Robert Francis, very much, because neither of us suggested having a chief inspector. Might I first ask you where the idea came from?

Mr Hunt: I certainly wouldn't say that I don't like the Health Committee; it is always a pleasure. I think that what we did—I have discussed this idea at great length—was follow Robert Francis's recommendations to their logical conclusion. He said that there was regulatory complexity and there needed to be regulatory responsibility instead, so that within the system everyone knew precisely who was responsible for what. I concluded on that basis that there needed to be one organisation that was responsible for making a judgment about how well a hospital was performing, and that should be the CQC, with a new chief inspector of hospitals—and then that the responsibility for fixing problems when they are identified should lie elsewhere, so that there would be no conflict of interest whereby the person who made the judgment that there was a problem was then wrapped into saying, "We do think progress has been made," because they had been part of the team implementing a solution. It was in order to get that regulatory simplicity and accountability in the system that I decided this would work.

I will be open with you; you may have a different view, judging by your earlier comments, but I do think that the Ofsted model in schools has transformed state education. Over the last 20 years there has been a real improvement in standards in state schools because parents know how good their local school is. It is much harder to get that information about your local hospital.

Q547 Valerie Vaz: Let us go back to the chief inspector. I think I asked you in the Chamber, when you first made the announcement, who they would be accountable to. It will not be yourself or the Commissioning Board; is that right? They are just accountable to—

Mr Hunt: The chief inspector of hospitals is accountable to the public.

Q548 Valerie Vaz: Yes, but how? There should be a link. I am just asking. I do not know. This is your idea.

Mr Hunt: Yes, I know.

Q549 Valerie Vaz: I am just asking you to help us. Help me.

Mr Hunt: The chief inspector of schools—

Q550 Valerie Vaz: Don't use the analogy: just tell us how it is going to work.

Mr Hunt: I am about to tell you, if you would be kind enough to let me answer your questions. The chief inspector of schools is accountable to the board of Ofsted, but actually their responsibility is to the wider public because their job is to tell the public about the quality of state schools. I want the chief inspector of hospitals to be accountable in the same way.

Q551 Valerie Vaz: So they lie within the CQC; that much we know.

Mr Hunt: Correct.

Q552 Valerie Vaz: It would be the CQC that, presumably, in its accountability to Parliament, comes before us, and presumably we can question the chief inspector. Is that right?

Mr Hunt: Yes.

Q553 Valerie Vaz: Will the chief inspector have power to shut down a hospital if they want to?

Mr Hunt: They will have the power to trigger administration, yes. If they identify failures and breaches of fundamental standards, if they categorise a hospital as failing, there will be a maximum period within which those problems have to be addressed. If the hospital fails to address those problems within that period, they will be able to trigger administration for the hospital, yes.

Q554 Valerie Vaz: That is separately to, say, Monitor or the CQC itself. It is the chief inspector that has that power.

Mr Hunt: Yes.

Q555 Valerie Vaz: Solely.

Mr Hunt: Not solely, because Monitor also has power in different ways, but the chief inspector will have the power. The crucial change is that they will be able to make that decision on the basis of the quality of service offered to patients and not just on financial grounds, which has tended to be where the centre of gravity has been to date when it comes to administration regimes.

Q556 Valerie Vaz: So there is one inspector, but do they have sub-inspectors? Surely you are not expecting the one person to go round all the hospitals.

Mr Hunt: No, just as the chief inspector of schools doesn't go round every school.

Q557 Valerie Vaz: You are going to have sub-inspectors.

Mr Hunt: Yes. The chief inspector would have a team.

Q558 Valerie Vaz: Does that come out of the CQC budget?

Mr Hunt: Yes.

Q559 Valerie Vaz: Are they going to get extra money for this?

Mr Hunt: Yes.

Q560 Valerie Vaz: How much?

Mr Hunt: We are in discussions with them, but they will have as much money as they need in order to do this job properly.

Q561 Valerie Vaz: I don't know what "as much money as they need" means.

Mr Hunt: They will have the money they need to do this job properly. When those figures have been bottomed out, of course we will make them available to Parliament.

Q562 Valerie Vaz: Do you know roughly what the time scale for that would be?

Mr Hunt: The chief inspector is going to be starting his or her work before the end of the year so you will have the information long before that.

Q563 Valerie Vaz: What kind of salary level will they be at?

Mr Hunt: It will be whatever salary is necessary to get the right quality of person to do this job, but it will be a peer-review process. The important change from the way the CQC operates at the moment is that the people inspecting hospitals will be people who know how to run a good hospital, and what to look out for. It will be people who are more experienced, and indeed more expensive salary-wise, than the current CQC inspectors.

Q564 Valerie Vaz: With the greatest respect, it was this Committee that decided that the CQC needed slightly reforming, and then David Behan was put in place and then David Prior, so we should be taking some credit for that. What we found was that this was an organisation in transition. I am just hoping—and asking—that you will think carefully about whether foisting something like this on it is a good thing to do at this point. You have decided on it without consultation, and you have decided this is the right thing even though the Select Committee and Robert Francis have said it was not really part of the whole make-up on patient safety and what happened at Mid Staffordshire. This is just a request that you think through carefully what they are going to do, because I do not want to envisage a kind of Bruce Keogh situation, where someone who is not really accountable to you, and not really accountable to Parliament, just goes and closes down a hospital on maybe a different kind of evidence, or evidence that is not out in the public domain.

I said I would bring up Stafford hospital, and we have seen the same thing again. There is very much an attitude of, "As soon as something goes wrong, let's shut it down," and I do not think people see the consequences of that. Can I have assurances from you that that is not going to happen under this regime?

Mr Hunt: I would not characterise the regime in that way at all. This regime is making sure that, where there are problems, they are addressed a great deal more quickly than happened in Mid Staffs. The idea of having a rigorous independent peer-review inspection system for hospitals is to make sure that we root out problems much more quickly and that all hospitals see themselves as on a stairway of excellence progressing

in the right direction. That is the intention of the new system.

Far from this being foisted on the CQC, the CQC are embracing this with great enthusiasm because they think that this is an inspection model that will work. They recognise that this will de-conflict them, because they will not be responsible for putting problems right. Their job will be to identify where there are issues and also to encourage all hospitals to strive for excellence. That is a very simple, clear role—a role that they are embracing with great enthusiasm.

Q565 Valerie Vaz: Yes, and I think we all want that outcome, but we certainly heard from them that they were making inroads into having specialist inspectors in specialist places. We will wait to see, but I just say that as a plea.

May I take you to something else that you have suggested? Will hospitals that are rated as outstanding have an incentive of greater freedom from regulation? That is what you have kind of said, isn't it? In which case, if you have a hospital that is rated outstanding, how long are they rated as outstanding, and when are they just left alone and have less regulation?

Mr Hunt: We will be consulting on this over the course of the summer. The thinking is that where we have confidence in the leadership of the hospital, and that they are outstanding in their performance, less burden will be put on them in terms of the normal CQC regulation. However, there will be constant monitoring of things like mortality rates and surgery success rates, so there will be lots of indicators that could prompt an unwarned inspection by the CQC. It is not that we will not be keeping an eye on how those hospitals are performing; indeed, we want that information to be in the public domain. But where we have confidence, we think it is right that they should have—I think a former leader of yours used this phrase—earned autonomy. I think that works in the context of good, well-performing hospitals.

Q566 Dr Wollaston: Secretary of State, you have rejected the recommendation to have regulation of healthcare assistants, who are delivering most of the care in our hospitals—and, of course, in the wider community. Could you tell us why you have rejected it and gone for a vetting and barring scheme instead?

Mr Hunt: I absolutely accept the spirit of what I think Robert Francis is trying to achieve in that recommendation, which is that the public should know that all the healthcare assistants working in NHS hospitals have proper training, and that if they are found to have committed a breach of care they should not be able to get a job in another part of the NHS or the health and social care system. I was concerned that introducing a regulatory superstructure for hundreds of thousands of healthcare assistants might end up being a tick-box computer exercise. So what we have decided to do is to achieve that through a vetting and barring system. We will set up a system whereby people who are found responsible for a breach of fundamental standards would not be able to get a job elsewhere, and also introduce minimum training standards. I think we are achieving the same thing in a different way.

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Q567 Dr Wollaston: Did you talk to health visitors themselves about what they felt the right way forward would be?

Mr Hunt: Not personally, but we are consulting on all these changes and I think that, hopefully, if they have some good feedback we can incorporate that into how we implement those two schemes.

Q568 Dr Wollaston: Are you happy, however, that having a vetting and barring scheme will address the underlying issue, which is how we give healthcare assistants greater continuing professional development and bring in aspects of appraisal? It does not have to be a tick-box scheme. There are other things about regulation, aren't there, such as a sense of the job being more recognised?

Mr Hunt: I agree, and Camilla Cavendish is doing a review for us at the moment. By the way, I am trying to get all these reviews to report before the summer break, because it is kind of "review city" at the moment. I want them all to report quickly because I want to implement their findings. Camilla Cavendish is looking at the whole professional recognition of healthcare assistants, and you are absolutely right about that. Incidentally, one of the changes in nurse training that we are trying to achieve is to create a much easier pathway for healthcare assistants into nursing. So we absolutely do want to improve that professional recognition.

Q569 Dr Wollaston: On that wider note, I am sure you would be very welcome in Torbay, to roll up your sleeves and come and do some work.

Mr Hunt: Maybe I could go to the Wollaston surgery.

Dr Wollaston: I hope you will apply for the job.

Q570 Barbara Keeley: Robert Francis recommended the introduction of a new status of registered older people's nurse, to recognise the special requirements of caring for the elderly. It would seem, as there is such a large population of older people in hospital now, that that would be an important recommendation. I think it would be an important step forward, but you do not seem to agree, Secretary of State. Could you tell us why?

Mr Hunt: Una might have some comments on that because she has thought about the issue a great deal. I do think that improving skills around geriatric care is very important. We did think, and are still thinking, about that recommendation very carefully. We just did not want people inside the nursing profession to think that older people's care was the job of specialist other people, when actually this is something that is central to everything that all nurses have to do in the modern NHS. It was about working out the right balance.

Q571 Barbara Keeley: But recognising expertise might show that it now has an importance which it previously did not have.

Una O'Brien: We have thought about this very seriously, and we still continue to want to hear people's views on it, although our instinct is that there is a risk of putting older people's nursing into a silo, which is the opposite of what we want. Going round any hospital today you will find older people on pretty

much every ward, except the children's wards. There will be people in the cancer wards, people in as day cases, and people on long-stay wards. So there are issues to do with care and support for elderly people in pretty much every place in a hospital.

The question that we are now wrestling with is: is the curriculum sufficient? We are going to be working with Health Education England to really look at the nature of the primary nurse education that we are commissioning, because the state does pay for pretty much all of that and we have a very big influence over that curriculum. It is really about looking at the place where we can have the biggest impact, as well as taking the full spirit of what is in the recommendation. It is not that we disagree with the underlying intent, but—quite the opposite—it is trying to find a way that will have the biggest impact.

Q572 Barbara Keeley: Perhaps a thing to take on board, if you are still thinking about it, is that local councils have done a good job in terms of having older people's champions.

Una O'Brien: Yes.

Barbara Keeley: Of course the Opposition, the Labour party, has a shadow Minister for Care and Older People. Increasingly that is well supported, in that people think it is a good idea to recognise that there are some special things about that expertise and specialisation that should be recognised. So I would go for it, but that is my view.

Chair: One of the things the Committee comes under pressure about is the exciting subject of death certification reforms. David volunteered to ask about this.

Q573 David Tredinnick: Certainly. I was waiting for your lead, Chair. Do you commit yourself, Secretary of State, to introducing the death certification reforms enacted in the Health and Social Care Act 2012 by the announced date of April 2014?

Mr Hunt: I have to apologise to the Committee because I think the dates may slip from the dates that I wrote in the letter that I sent to you, Chairman, last December. There are some implementation issues. We are absolutely committed to the reform. There have been some implementation issues with regard to the charging regime and the co-operation with local authorities, who are going to have a pivotal role in this. I do not know whether you want to add to that.

Una O'Brien: This is something that we feel very strongly about—ensuring that it is safely implemented. It is the biggest reform of death certification in 50 years, as I know the Committee understands: the medical certificate of the cause of death and then the introduction of the role of the medical examiner. What we are working with at the moment are the draft regulations which we want to put out to consultation. That is where there has been a delay because—

Q574 David Tredinnick: When is the consultation going to take place?

Una O'Brien: I am very much wanting and expecting that consultation to take place imminently. We want a whole Government consultation that captures the

issues for the Home Office as well as for the MOJ, and we are just in the process of resolving those issues between the three departments. But there is no let-up in the commitment to making this happen.

Q575 David Tredinnick: Right. Are you going to accept all the Francis report recommendations on improvements to the system?

Una O'Brien: As far as I can tell, they are consistent with what is proposed, but we have not addressed the specificity of those recommendations in this initial response. I have gone back and double-checked those recommendations, and they look to me to be broadly consistent—but, as I say, we are going to have a further response in the autumn that will go through each and every recommendation and clarify the position on this.

Q576 David Tredinnick: I used to chair the Joint Committee on Statutory Instruments, and I see from a letter that you wrote, Secretary of State, that you were hoping to submit statutory instruments—four of them—to the JCSI in June this year. Has that slipped? Presumably it has.

Mr Hunt: It has, I am afraid, and that is why I wanted to express my apology to the Committee. It is one thing that is taking a bit longer than we anticipated.

David Tredinnick: Yes. The laying of draft fees regulations and the debating of the same later in the year will presumably slip a bit.

Q577 Chair: May I suggest, Secretary of State, that it might be helpful if you wrote to the Committee with a revised timetable for the implementation of what is in the Act, and also any reflections on what Francis recommends ought to be added to the provisions of the Act?

Mr Hunt: I will do that.

Chair: Thank you.

Q578 David Tredinnick: Chair, with your indulgence, may I ask this? There are 14 hospitals now under investigation by Sir Bruce Keogh and his team on the grounds that they are persistent outliers on at least one national mortality indicator. Given that there have been long-standing concerns about the reliability of death certification in hospitals, can you be confident that their mortality data are reliable?

Mr Hunt: Shall I start on that? The answer is that mortality data is an incomplete indicator. There may be reasons why those hospitals are perfectly safe but, as we discussed earlier in the case of Leeds, the data is not correct. Because mortality rates were one of the lead indicators in the case of Mid Staffs that were not taken seriously quickly enough, we thought it was appropriate to do this research into those hospitals and to make sure that where there appeared to be issues they were being addressed. This is a kind of bridging process while we set up the much more thorough inspections that are going to be done by the chief inspector of hospitals.

Q579 David Tredinnick: Can you, or we, trust any NHS death certification and mortality figures at the moment?

Mr Hunt: I think the answer is yes, but they have to be treated with caution, because excess mortality is excess against a mean. It does not mean that every example of excess mortality is an avoidable death, but it does mean you should investigate—and that is what is happening.

Q580 Valerie Vaz: Are you satisfied that those 14 hospitals are the right ones?

Mr Hunt: They are the outliers in terms of mortality statistics.

Q581 Valerie Vaz: Are you satisfied?

Mr Hunt: We should definitely investigate mortality outliers, yes.

Q582 Chair: When we asked Professor Nick Black what conclusions he drew out of excess standardised mortality, he told us that, if you look behind the data of the outliers, you find that avoidable deaths are actually a constant proportion of deaths reported by hospitals wherever they are on the statistical analysis of standardised mortality. In other words, standardised mortality is not a reliable indicator of avoidable deaths. Is that an observation you either contest or take into account in your policy making?

Mr Hunt: It is one that we are neutral about, because we recognise that they are not a complete indicator of performance. This is an evolving science, but we think it is right to investigate where we think there are outliers. That is what we have decided to do. It is one of the things that I am sure will exercise the new chief inspector of hospitals a great deal, because they will have to make a decision as to where they want to do snap inspections if they think things are going wrong. They may look at that and at other things that prove to be quite reliable indicators of problems, such as high rates of staff saying that they would not want their own family to be treated in a hospital. So I think there are a number of indicators that you would keep under review, but just while we are setting the system up we thought this was the right thing to do.

Q583 Chair: It was quite striking in your answer to David Tredinnick that you said you were focusing on standardised mortality because it happened to be a lead indicator where problems were proven to exist in Stafford. Actually, if you analyse the use of SMRs round the system, the evidence appears to suggest that it is not a reliable indicator of avoidable death.

Mr Hunt: I understand that debate. The truth is that people will need to look into this kind of issue in a great deal more detail as part of our new hospital inspections regime. I thought it was prudent to take immediate action because it was a lead indicator for avoidable death at Mid Staffs. That is why we decided to take the action we did.

Q584 Barbara Keeley: Moving on now, we have the spending review in a few months' time, and we still have the Joint Committee's report on the Draft Care and Support Bill, on which three members of this Committee did an excellent job for four months, so we support it. Could you tell us when you intend to respond to that Joint Committee report, and whether

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there will be an opportunity, for instance on piloting, to propose how you would implement the cap on care costs and other issues before the Bill is formally brought in? We wanted, as a Committee, to look at guidance and detail, and we were not able to do that because of the timing of the Committee and the out date we had. For instance, there are fears in local government about the impact on them. So will there be piloting? When can we see a response, and will there be piloting of how it will work?

Una O'Brien: There is going to be a reference to the Bill in the Queen's Speech. The impact assessment, which will give a lot more detail on the points you are raising, will be published shortly after that, with the Bill in its form to come forward for first reading.

Q585 Barbara Keeley: We know already that the Government's proposal is that the cap and other measures will have effect from April 2016, the date having originally been set as April 2017. Do you think—I do not know, Secretary of State or Una, whoever wants to answer it—that that could be brought forward? Or could there be some interim measures? For instance, evidence was put forward that changing things like the means test threshold levels could be done without a Bill. That could be done as soon as you wanted it to be. So is there any prospect that that will be coming forward, and are these things that might be laid out in the spending review?

Mr Hunt: We would love to do them as soon as possible, but I am afraid these things are all subject to public finance. I was delighted when it was brought forward from 2017 to 2016, but it is just a question of what the other pressures are on public finance.

Q586 Barbara Keeley: Okay. When you last gave evidence to this Committee in November you said that you would be looking at resuming cross-party talks. There are still some elements of this that it is important to get cross-party support for, and a debate out there among the public about these measures so that the public are ready for a solution when it goes ahead. Is that something you intend to take forward?

Mr Hunt: I am very happy to have cross-party talks if my opposite number would like to do that.

Q587 Barbara Keeley: I think he has indicated again and again that he would.

Mr Hunt: All I would say is that I am not aware of any great issue of contention on those particular proposals, but I am very happy to engage with him—

Valerie Vaz: You are going to our team.

Mr Hunt:—by all means.

Q588 Dr Wollaston: Both this Committee and the Joint Committee on the draft Care and Support Bill made recommendations that we should make it far easier to bring forward integration of health and social care budgets. Can you perhaps update us and tell us how that is going to move forward?

Mr Hunt: Yes. I completely agree with that, and the next big strategic challenge that I need to focus on, following on from the Francis report and Mid Staffs, is the integration agenda. It is a big job. Part of it will be potentially through things in the Care and Support

Bill, but there are lots of other things that will not necessarily need primary legislation where there are barriers—things like what we can do to encourage pooling of budgets, the way primary care operates, the technology agenda, which is very linked to that, the way payment by results works, and the system-wide disincentives to the pooling of budgets. So there is a very big piece of work that we need to proceed with apace.

Q589 Dr Wollaston: I am glad to hear that. There is one area where integration is already at an advanced stage in Torbay, but they are finding that there are barriers being put in the way of proceeding with integration. In fact, if anything, their whole system is under threat. Very specifically, the issues are that they are being forced to use their foundation trust pipeline for their care trust where the care trust is not financially viable enough to survive on its own. There are also issues around the involvement of the Office of Fair Trading. There is a single sole bidder for the care trust, and that is the local foundation trust. Our understanding, as a Committee, was that Monitor would be able to make a judgment as to whether that was anticompetitive or whether it should go ahead. But in many areas I know—such as Bournemouth—these kinds of decisions are being held up very significantly by another raft coming in with the OFT. Is there any encouragement that you can give organisations like Torbay that this can all be streamlined, because it could completely disintegrate?

Mr Hunt: It is immensely frustrating when you hear stories like that. The only thing I can say, which is as encouraging as politicians' words can ever be, is that we really do want to address those issues. In the next few months we want to look at what the system-wide barriers are. Some of them are matters of European law, which is very difficult to change. There are a lot of things that we can do which do not involve changing European law that could make a very big difference.

It is absolutely essential that we do this. The people who most need better care and treatment than they currently get are frail elderly people with long-term conditions. Those are the people who need a properly joined-up service—whichever part of the system they are in—which knows what other parts of the system have been doing, where there is clear responsibility for their care, and where there is a clear determination to make sure they have a joined-up care plan. That is absolutely essential. It is the next big bullet the NHS has to bite. It is completely understandable that our focus has been on hospital care in the wake of the Francis report, but it is very important that we put as searching a spotlight as possible on the quality of care for the frail elderly outside hospital and the system-wide barriers to making that care of the standard that we would all want.

Q590 Dr Wollaston: I would just like to reflect on the fact that this Committee visited Denmark and Sweden, and when we were in Copenhagen they showed us slides of the Torbay model. So it is not just recognised nationally; it is recognised internationally. If the Torbay model, which is internationally

recognised, were to disintegrate because of barriers being thrown in its path, it would be an absolute tragedy. Can you assure the Committee that you will look closely at the specific issues that it and some other trusts are facing?

Mr Hunt: Yes, I can.

Q591 Chair: Can I enlarge on that a little? As these expressions of concern about integration have come forward, they have tended to focus on the proposition that either Monitor, or sometimes the OFT, are interesting themselves in a commissioner's interest in commissioning—not providing—integrated pathways of care. My understanding is that it has always been the Government's position that there is no basis on which a commissioner's desire to commission an integrated pathway of care can be challenged on competition grounds. If that is correct, would your door be open to any commissioner who feels that their desire to commission an integrated pathway of care is being challenged by the competition authorities?

Mr Hunt: How you have described the Government's position is exactly how I want it to be, but the work that I need to do in response to what Sarah and other people have said is to look at precisely where any legal barriers might be. Sometimes these legal barriers are imagined and sometimes they are things that are real. But I am clear that this is a very important piece of work, and perhaps something on which, if the Committee were interested, we could have a whole session on what we can do to deal with those issues.

Chair: It will undoubtedly come up in the inquiry that the Committee has already announced into the implementation of the Health and Social Care Act, because it is one of the understandings the Government made clear during the passage of the Act. Andrew does want to come back to the question of healthcare assistants.

Q592 Andrew George: I will come back, because it seems that we have been very efficient with our time. I want to ask about the regulation of healthcare assistants, home care workers or those care support workers that exist. We have just been talking about integrated care, so this is something that really applies across all sectors if we are to have an effective health and social care service. All the management regimes that exist seem to be increasingly putting on pressure through cost-centre management on the lowest-cost suppliers of service, who are the healthcare assistants and healthcare workers. You have rejected the proposal that those people be regulated. Why is that? What would be necessary in order for you to change your mind in that respect?

Mr Hunt: I am not going to implement a measure unless I can see that the measure we are talking about is going to make a measurable difference in improving standards of care. In fact, when you talk to Julie Bailey and some of the families from Mid Staffs, they say that some of the best care they found in Mid Staffs was from healthcare assistants. The concern that people are trying to address is about where there is inadequate training, or where the wrong person has been able to get the job. I think that we can address those in another way. What I am worried about is

creating a national bureaucracy that does not address those issues but allows people in hospitals and other parts of the system—care homes—to say, “It's all right, because we've complied with the statutory regulations. Therefore everything is fine,” when what matters is the way people are managed, whether they get proper training, whether we have a robust way of making sure that people who have been convicted or found guilty of abuses of care in other parts of the system are unable to get jobs elsewhere. Those are the main issues that we need to address. We can address those more effectively by doing other things.

Q593 Andrew George: You must acknowledge that, although Julie Bailey may well be satisfied, in many other areas there have been failings in that particular sector itself, and that has been found not just in hospitals but indeed in the home care sector and elsewhere. Given that there are also concerns about nurses who depend increasingly on healthcare assistants to perform their functions, there is a missing element, if you like, of being able to identify clinical symptoms because you do not have a trained professional undertaking personal care of that patient. Given that—as you have even mentioned yourself—there is a need for training for healthcare assistants to perform a wide range of the functions that we are increasingly expecting them to perform, I cannot see why you have rejected the proposal to introduce regulation. Surely you must accept that this would enhance their professional status, which can only do one thing, and that is to enhance the quality of care.

Mr Hunt: I do not believe that would happen, and I am worried that it would end up being a bureaucratic process. I do not want to repeat myself, but I think we can address the concerns.

Let me make a broader point, though. Of course there are some bad apples in any profession—I am sure members of the public would say there are some bad apples in Parliament as well—but it is a mistake to respond to Francis by saying that the main thing we need to do is to be better at rooting out bad apples. You talked about home care, and one of the most frequent complaints we hear, which worries me greatly, is the concept of a 15-minute slot when someone goes in to look after someone needing care and has time either to give them a meal or to wash them, but not both. When that happens it is not the responsibility of the healthcare assistant; it is the responsibility of the system that is only giving people those 15-minute slots. People who become healthcare assistants and nurses do so from the best of motives. It is about sorting out those system-wide problems that, as I think Professor Pearson said, can drum the compassion out of people, because they are pressured into behaving in ways in which they do not want to behave. It is important that we address those underlying issues rather than just thinking that this is about striking off more nurses from the NMC, or statutory regulation of healthcare assistants.

Q594 Dr Wollaston: On measles, may I ask you about the national epidemic? I received a very moving e-mail from the parent of a child who has leukaemia whose immune system is suppressed, and he rightly

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makes the point that this could be an unfolding tragedy not just for his own family if his son contracts measles but also more widely across the country, with many children who are too young or too unwell to be vaccinated. There are parts of my constituency in particular—I raised this with you recently—where 30% of children have not been vaccinated against MMR. The point that the father who has written to me wants me to raise with you—I also share his concern—is whether it is now time for us to have a national campaign, a catch-up campaign, to help protect these families. Is it not time that we stopped using this term “herd immunity” and talked about “community immunity”, because when you immunise your child you are protecting children like his son, who are in very grave danger if they contract measles?

Barbara Keeley: May I amplify what Sarah is saying? We have had a significant rise recently in Salford, but just in certain parts of the city, mainly among children and young adults who were not immunised in the 1990s. We have gone from having very low numbers to, at the end of last week, having nine cases confirmed, and a very much larger number of cases suspected and confirmed this year. So it is not just Wales. There is a perception that it is just Wales. The reason we need a national campaign is that it is in other cities too, and we now have this concern in Salford.

Mr Hunt: I completely agree with that. The concept of community immunity is a very good one and we certainly must not think of this as something that is happening only in Wales. I am receiving regular updates from the chief medical officer. We have comprehensive plans in place, and we need to use this as a moment to slay the myth about MMR. I do detect a turning point in terms of the public’s attitudes towards this, but there is still that critical 11 to 15-year-old age group that may not have been vaccinated because they were toddlers at precisely the time when the MMR scare was so appallingly whipped up. But I agree with your concerns. I want to reassure you that we are taking this extremely seriously inside the Department of Health and we absolutely do want to make sure that we do everything we can to protect people like the person whose father contacted you.

Q595 Dr Wollaston: Will that involve a national campaign now to bring it home to people that they do need to act—a national media campaign?

Mr Hunt: If you are talking about a national plan, yes. As to the precise role of publicity in that, which is what people normally mean by a campaign, I would be guided by the chief medical officer as to the moment she thought that was appropriate. In terms of making sure that we have sufficient numbers of vaccines, making sure that we are talking in a targeted way to communities and schools, that is something that absolutely is going on.

Q596 Barbara Keeley: I do not think we are yet seeing the mass turn-out that we need to have of those families that need the vaccination for their teenagers in Salford. The message did get out in Wales but it has not got out in places like Salford. So we are seeing

pleas and things in the local paper and online, but it requires more than that because people need to be convinced that they have to do it.

Mr Hunt: I will relay those concerns to the chief medical officer. My understanding is that she feels that we have good plans in place, but I will relay those concerns and make sure that I am satisfied, on the basis of what you have said to me today.

Q597 Valerie Vaz: I have just a few more questions. I touched on Stafford hospital earlier, and I wonder if you are aware of the strength of feeling about what has happened at Stafford hospital, and if there is anything that you are doing about it to consult with local people, or even the MPs.

Mr Hunt: There is a process that has been set in train. I have to respect that process because it is set down in regulations. I am very aware of the concerns of the people of Stafford, but I hope you understand that, because in the end that decision will arrive on my desk, I cannot make a comment on that particular case at this stage.

Q598 Valerie Vaz: It seems to me that we are here because of Stafford—that is what we are discussing—and that takes me back to the Francis report. He did indicate there was a problem between Monitor and the CQC, and that does not seem to have been resolved in your response.

Mr Hunt: I very much hope that is not the case. One of the most substantive parts of our response is to clarify the respective roles of Monitor and the CQC so that there is absolute clarity about who is responsible for what. Those are the changes we have been discussing today concerning the chief inspectorate of hospitals. Monitor has a very important role there. Its job, as the regulator for the FT sector, is to sort out problems as and when they are identified. That is a big responsibility, but that is what it has to do. We need a system where it is not possible to duck problems, because it is always difficult to address those problems. It is particularly difficult—it is worth saying—for politicians to address these problems, because we all know about the unpopularity of reconfigurations. But, where patient safety is at risk, it is incredibly important that these issues are addressed.

Q599 Valerie Vaz: I understand that, but there is an independent reconfiguration panel, and it goes to the heart of what happened at Leeds and at Glenfield. There is a process, and that does not seem to be being applied. The same goes for A and E. I do not think you quite realise that, sometimes when A and Es are closed down, it has an impact on other hospitals.

Mr Hunt: I most certainly do realise that. I would strongly refute your suggestion that the process is not being followed. In this case it is being followed. It is very important that it should be followed, and when it comes to reconfigurations involving A and E we have made it very clear. We have done something that was not done before: we have introduced the four tests which we have said must be met before any reconfiguration happens, precisely because we are aware of the concerns of the public.

We are also doing broader work about how A and E works generally, because we have pressures on A and E at the moment, which are significant, but also because there has been a failure of the system to persuade the public that there is anything credible in between a GP surgery and an A and E. All the kinds of things you can have in the middle—urgent care centres, or whatever—have not succeeded in giving the public confidence in what they do. That is another reason why Bruce Keogh is doing his review of what our overall strategy should be. Bruce Keogh seems to be doing quite a lot of reviews these days, but this is an equally important piece of work that we will hear back on, which will help to inform all of us as to the right way forward.

Q600 Valerie Vaz: I think that is because people were not expecting this reorganisation from the Health and Social Care Act. That is why. I am sure we could all work together.

May I move on finally to the section 75 regulations? I am sure you are aware that there are still some concerns about them, particularly among the royal colleges, and I wondered if you were going to withdraw them and redraft them again.

Mr Hunt: We have withdrawn and redrafted them.

Q601 Valerie Vaz: But there are concerns about the redraft.

Mr Hunt: I think we have addressed the concerns of people in the House of Lords. For the record, you should understand—as I am sure you are aware—that what we are putting in are the same procurement regulations that applied to the previous PCTs. They reflect the guidance that the last Labour Government put out to PCTs, which they said they must follow if they were to comply with European procurement regulations. That is what those section 75 regulations do. There has been a lot of mischief about the purpose of those regulations. Let us be clear that the purpose of the Health and Social Care Act was to insert clinical leadership and local decision making into procurement decisions. It was not to create a competition free-for-all, and that will not be the impact of these regulations.

Q602 Valerie Vaz: But people do feel that that is the case. Are you saying that you are not going to redraft them?

Mr Hunt: I look forward to you very generously going out and informing people of the reality of those section 75 regulations so that they don't feel that is the case.

Q603 Valerie Vaz: Are you saying you are not going to redraft them?

Mr Hunt: I have already said that. By the way, I also do not think that what is happening in Stafford hospital is about the Health and Social Care Act; it is about making sure that when there are serious problems in the system we do find a sensible way of addressing them.

Q604 Valerie Vaz: I was not suggesting that, but anyway. May I ask you about one thing in the Government's response which I do not understand? Perhaps you could clarify what it means. One of the points was that you have said that pay will be linked to quality of care delivered rather than simply time served. Could you expand on that, and say how you would measure it, and who will be measuring the quality of care to enable people to get, what—performance-related pay?

Mr Hunt: We will have, as a result of the new structures that we are putting in place, much better ways of measuring the quality of care delivered in hospitals. The rolling out of the “friends and family” test will be one of the measures, but the judgments made by independent inspectors about the quality of care will also be explored, and we would like to see more link between the quality of service delivered and pay. On the other hand, I would not want to create a structure where people felt that you had to be paid to deliver a high quality of care, because I think this is core to what people in the NHS do.

Q605 Valerie Vaz: So that does not say that, then.

Mr Hunt: No, it does not. I do not think that compassionate care is something you buy; it is something that you create, a culture that you can nurture. We are working through how to get that balance exactly right.

Valerie Vaz: Thank you.

Q606 Grahame M. Morris: I have a question about the section 75 regulations. The implication of the Secretary of State's answer was that there are just one or two politicians who say that this is going to open up the service to privatisation. In fact, there is a recognised body of opinion—consisting of the British Medical Association and a whole raft of organisations—that has warned that that is precisely the consequence. I firmly believe it was the intent as well. The suggestion is, “Oh well, this is only a minor change.” It is not. It is fundamental, and it will open up the national health service to wholesale privatisation. I wish you would just be clear about that.

Mr Hunt: It will not. I am not sure this is something that we can resolve now. All I would say is that, as it is completely consistent with the procurement regulations that your own Government put in for the PCTs, you have to show what is different if you are going to justify the assertion that this is about enforced privatisation—which it most certainly is not.

Chair: This is a story that will run, and probably not achieve consensus.

Grahame M. Morris: Yes, and we won't have a health service in 2016.

Chair: Thank you very much for your time, Secretary of State. We have covered a lot of ground and we shall have a report in the next few weeks. Thank you very much.

Written evidence

Supplementary written evidence from the Department of Health (FRA 04)

QUESTION 287—NHS SEVERANCE PAYMENTS 2008–09 TO 2012–13

The Department only holds data since 1 April 2008.

	2008–09		2009–10		2010–11		2011–12		2012–13 (as at 1 March 2013)		Total	
	Number of cases approved by HMT	Total Value of Approved Payments £	Number of cases approved by HMT	Total Value of Approved Payments £	Number of cases approved by HMT	Total Value of Approved Payments £	Number of cases approved by HMT	Total Value of Approved Payments £	Number of cases approved by HMT	Total Value of Approved Payments £	Number of cases approved by HMT	Total Value of Approved Payments £
Total	192	5,990,504	130	2,490,968	35	508,174	38	1,038,906	12	120,939	407	10,149,491

A robust system is in place for authorisation. All payments have been agreed firstly by the NHS organisations remuneration committee (members are all non executive directors), then supported by the relevant SHA, and the Department and finally approved by HM Treasury. Many cases are not approved during this process. Over this 5 year period 30% of cases were rejected by the Department alone.

The Department is not informed of actual payments. The approval is the maximum that an NHS organisation (NHS Trusts, PCTs, SHAs and Special Health Authorities) is authorised to make.

The 10 largest severance cases authorised since 2008–09 are as follows:

	Organisation Name	Value of Approved Payments £	Value of Contractual Element £	Year
1	South Central SHA	674,223	644,223	2008–09
2	Plymouth Hospitals NHS Trust	300,000	0	2008–09
3	Ealing Hospital NHS Trust	220,400	149,868	2010–11
4	Leeds Teaching Hospitals NHS Trust	204,000	0	2009–10
5	NHS London	176,985	88,492	2009–10
6	Royal West Sussex NHS Trust	150,000	0	2008–09
7	Mid Essex Hospital Services NHS Trust	125,000	0	2008–09
8	Great Ormond Street Hospital	120,000	22,552	2008–09
9	London SHA	117,000	107,000	2008–09
	The Lewisham Hospital NHS Trust	100,000	0	2008–09
10	Surrey PCT	100,000	0	2008–09
	Imperial College Health Care NHS Trust	100,000	0	2008–09

March 2013

Supplementary written evidence from the Department of Health (FRA 04A)

During my appearance before the Health Select Committee on 23 April, I agreed to provide the Committee with further information, which I have set out in this letter.

CHILDREN'S HEART SURGERY AT LEEDS HOSPITAL

The Committee asked for a full timetable, detailing when the Department received information relating to mortality data at Leeds Hospital.

The decision to suspend surgery at the Leeds unit was taken because concerns had been raised from a variety of sources about the safety of surgery at the unit. The hospital decided to close the unit.

In any decision about the suspension of services, the ultimate consideration is patient safety. We support NHS England and the Trust in coming to a joint decision about what is best for patients, and I am pleased that surgery has now resumed for low-risk patients.

The closure of the children's heart surgery unit in Leeds is separate from the national review of children's congenital heart surgery and is not connected to the court proceedings in which a Leeds-based charity Save Our Surgery won its judicial review against the decision to close the unit.

A full timeline of events is set out in Annex A.

HEALTH EDUCATION ENGLAND PILOTS

The Committee asked to see additional detail regarding proposals for nurses to undergo a year's training as a healthcare assistant, prior to beginning a nursing degree course. This information is set out in Annex B.

DEATH CERTIFICATION

The committee asked for a full revised timetable for reforms to death certification, that takes into account the recommendations made by Robert Francis. I would like to advise the Committee that we intend to engage further with our key partners to inform the timetable for the reforms over the coming weeks. I will then write to the Committee with further details by the end of this month.

I do hope that this information is helpful, and would of course be happy to provide further detail as requested.

Rt Hon Jeremy Hunt MP
Secretary of State for Health

8 May 2013

Annex A

CHILDREN'S HEART SURGERY AT LEEDS HOSPITAL: TIMELINE

Earlier this year, the office of Sir Bruce Keogh received correspondence from the Children's Heart Federation expressing concern that children were not receiving the level of service that should be provided to them at the Leeds Unit, and that the Leeds Unit was not referring appropriately to other centres.

During 2013, the Medical Director of Leeds Teaching Hospitals NHS Trust (LTHT) received complaints from cardiologists in LTHT alleging poor communication and poor team working within the Unit by one of their congenital cardiac surgeons.

26 March 2013—Sir Bruce Keogh received telephone calls from two paediatric cardiac surgeons and an eminent cardiologist. They expressed similar concerns to the Children's Heart Federation and additional concerns over surgical staffing.

27 March 2013—Sir Bruce Keogh was provided with a first draft of data from the Central Cardiac Audit Database (CCAD).

28 March 2013—Sir Bruce Keogh and the NHS England Area Director and Medical Director for West Yorkshire met the Chairman, Chief Executive and acting Medical Director of LTHT to discuss the concerns. A CQC representative also attended the meeting. A decision to suspend surgery at the unit was taken. Patients and families whose surgery was affected by this decision were notified.

28 March 2013—I was informed of the situation at LTHT by NHS England.

29 March 2013—Sir Bruce Keogh appeared on the "Today" programme and I spoke to three local lead MPs (Hillary Benn, Stuart Andrew and Greg Mulholland). LTHT continued to provide reassurance to the families involved.

4 April 2013—A risk summit, chaired by Dr Mike Bewick (Deputy Medical Director of NHS England), and attended by representatives from NHS England, NTDA, CQC and the Trust met to discuss the suspension further. The summit agreed that further work was required.

5 to 7 April 2013—Discussions continued between the Trust, NHS England, CQC and the independent review team to address concerns that had been raised.

8 April 2013—First stage of the review by a multi-disciplinary independent clinical team completed. It found:

- assurances could be given that the quality of surgery and staffing levels were sufficient to allow the phased resumption of operations; and
- the Trust's data for monitoring surgical results was uniquely poor, triggering concerns about death rates and gaps in information.

8 April 2013—Risk summit met to discuss the outcome of the first-stage review and recommended that surgery could re-commence on a phased approach.

10 April 2013—Surgery re-started at the Trust on a phased basis, starting with lower-risk cases.

A second stage of the review will now begin. This will comprise:

- a review of the way complaints from patients are handled, including the issues raised by the Children's Heart Federation; and
- completion of a review of patients' case notes over the last three years.

Sir Bruce Keogh will agree the terms of reference for this review within the next few days and will appoint an independent clinician to undertake this work. The findings of the second stage of the review will be considered at a future meeting of the Quality Surveillance Group and may lead to a further risk summit if required.

In addition, NHS England will further explore issues that have been raised about referral practices to ensure they are clinically appropriate.

Annex B

PILOTING A YEAR SPENT AS A CARER BEFORE ENTERING NURSING EDUCATION AND TRAINING

INTRODUCTION

To deliver high-quality care, we need staff in the right numbers, with the right skills and the right values and behaviours. The intention in asking those who commence NHS funded nursing degrees to first spend up to a year as a carer is to promote an experience of frontline care underpinned by those values and behaviours needed to work in the NHS.

Recommendation 187 from the Robert Francis Inquiry into the Mid Staffordshire NHS Foundation Trust said that “There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care”.

The Government response suggested that this should be tested to see if up to a year would be better, and asked Health Education England (HEE) to pilot and evaluate pre-degree nurses undertaking a year as a carer before recommending how it should be taken forward.

We believe this important development in nursing education will be invaluable in enabling prospective student nurses to gain hands-on experience whilst appreciating the care support roles and their vital place in delivering the best possible patient care.

This change will also help students to find out whether healthcare and nursing is right for them; attrition rates show that a significant number of students who start an undergraduate nursing degree do not complete the programme.

STEERING GROUP

A steering group will direct the pilot, chaired by Sir Stephen Moss. Stephen is a former director of nursing at Nottingham University Hospitals NHS Trust who was invited by Monitor to take on the Chair of the Mid Staffs NHS Foundation Trust after the initial Healthcare Commission report into standards of care at the Trust. His direct experience with the patients and families affected by the poor standards of care at the Trust will be invaluable.

The steering group will comprise key stakeholders including HEE and LETB directors, CNO Jane Cummings, PHE director of nursing Viv Bennett, NTDA director of nursing Peter Blythin, the NMC and the Council of Deans, representatives from the RCN and UNISON, NHS Employers, a provider Trust chief executive, Healthwatch, and Sally Brearley, chair of the Nursing and Care Quality Forum.

PILOTING A YEAR AS A CARER

HEE have made some early decisions on the scope:

- In line with the Department of Health’s mandate with HEE, the pilot placements will start by September 2013 with student experience evaluated by summer 2014 in order for them to commence their studies at the beginning of the 2014 academic year;
- Further evaluation will be undertaken to test the pilot’s efficacy in demonstrating and testing NHS values and behaviours; reducing attrition rates; giving experience and appreciation of a hands-on patient care experience, and building an understanding of a career in the NHS;
- Between 150 to 200 prospective nurse students will be selected for the pilot. Those undertaking placements will have to meet the academic entry requirements for their course;
- The placements will be paid jobs of one year in duration and will allow students to gain experience across different care settings. Through evaluation, this will allow HEE to determine the right length of experience needed, between the three months suggested by Robert Francis, and up to a year proposed by the Government; and
- Students will be recruited for NHS values and behaviours, and will sign up to the Skills for Health/Skills for Care code of conduct for care support workers and receive induction training to the minimum training standards. These were published in response to the Francis Inquiry recommendations.

The steering group will drive the implementation, management and evaluation of the pilot, considering how it will be arranged, and how students will be supervised and assessed. The scoping work will also take into consideration patient safety, the impact on nurse recruitment and the current nursing workforce, and the impact on hospitals as they support this change.

COST

The cost of the pilot is estimated at around £3.5m. The majority of this is paying people to do a real job, supporting the service, at Agenda for Change pay band 2. Other costs will be for the steering group, assessment tools and evaluation of the pilot. The steering group will work with providers and pilot organisations to agree the most appropriate approach to funding the pilot, recognising the extra responsibility we are placing on Trusts but also the added benefit they will gain from hosting these posts.

The Government's response to the Francis Inquiry recommendations said that the scheme will need to be tested and implemented carefully to ensure that it is neutral in terms of costs, and as part of this work we will undertake robust economic modelling and costing analysis—the results of which will form part of the final report.

There is more value to the NHS than just cost savings; the real value will be for patients and their families. Time spent as a carer will contribute to supporting the service with people doing real jobs, gaining front-line care experience, getting to know the NHS and other career options open to them, and understanding the interface with social care which is often key to patient recovery and long term wellbeing.

Supplementary written evidence from the Department of Health (FRA 04B)

DEATH CERTIFICATION REFORMS

When I appeared before the Committee on 23 April I promised to write to you with more information about our timetable for reforms to the death certification system, and about our views on the relevant recommendations that Robert Francis made. I apologise for not being able to give you an appropriately detailed reply at the hearing itself.

The first thing I want to stress is the Government's continuing commitment to implementing these reforms successfully. The potential benefits are, I think, clear—both for the recently bereaved and for the health and care system as a whole. The interest that Robert Francis has shown in the programme reconfirms its significance.

On timing, I have now agreed with the Local Government Association and other interested parties that we should aim for the new system to go live in October 2014. I realise that this represents a delay, which I regret. I know it may also disappoint the Committee. Nevertheless implementation is a major task, technically and administratively complex, and involving a number of different agencies. Our partners in delivery are unanimous in accepting that postponement until October is preferable to hurrying for an earlier date and thereby risking the system's stability. We expect to run the public consultation exercise this summer, and to lay the supporting secondary legislation in Parliament early in 2014.

Robert Francis made a number of constructive recommendations for the programme. Our response to them will be overwhelmingly positive, although there are one or two points that we need to discuss further with him and consider in more depth—for example, his proposal for the independence of medical examiners from their local NHS. Our position on the recommendations will be reflected in full in the consultation document.

I hope this answers the Committee's questions and reassures you. I would be happy to write again later this year with more information about progress if the Committee would find that helpful, and of course I would also be happy to discuss the issues further with you.

Rt Hon Jeremy Hunt MP
Secretary of State for Health

3 June 2013

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