THE MID STAFFORDSHIRE
NHS FOUNDATION TRUST
PUBLIC INQUIRY

Chaired by Robert Francis QC

Mid Staffordshire NHS Foundation Trust
Public Inquiry
Skipton House
Room 204A
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Mr Malcolm Alexander
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11 January 2012

Dear Mr Alexander

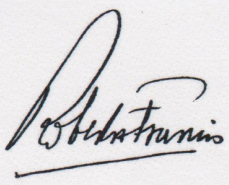
Mid Staffordshire NHS Foundation Trust Public Inquiry Seminars – copy of seminar report

I am writing to thank you for your contribution to my recent series of seminars for the Mid Staffordshire NHS Foundation Trust Public Inquiry. I was extremely grateful for the reflections and ideas to come out of the seminar discussions, which proved to be both lively and stimulating, and for the quality and thoughtfulness of the contributions made by all those who took part. Thank you for taking the time to support me in my work on the Inquiry.

I have enclosed, for information, a hard copy of the report of the seminars, which has been produced by Dr Sarah Harvey, who facilitated the events. An electronic copy is available on the Inquiry's website at: www.midstaffspublicinquiry.com/seminars. We have also placed on the website some podcasts of each seminar, along with copies of all the papers and presentations submitted.

As you know, these seminars were a little unusual in that they were designed primarily to benefit me in my work as Inquiry Chairman rather those taking part. However, I hope you will nevertheless find the report and the wider material from the seminars both interesting and thought-provoking.

With best wishes



Robert Francis QC
Inquiry Chairman

LOCAL GPs

30. The evidence from the GPs did not in general provide grounds for optimism nor for making positive recommendations. The lack of engagement both with the PCT and with the hospital itself was surprising. However the following issues might be thought to arise in this context.

31. PCTs (for the remainder of their existence) need to engage far more proactively with GPs who use the trust's services.

32. GPs, if they are to take on the commissioning role assigned to them, need to become far more proactive in engaging with their patients post the hospital experience. They need to have systems to discover what the patient's experience in hospital was and what the outcome of the treatment was.

33. GPs need to have a system of communication with each hospital whose services they use to feedback the patient experience both when there are good outcomes and poor outcomes. There needs to be a single identified senior clinician within each trust with specific responsibility for communicating with local GPs.

34. The patient experience needs to become embedded in the commissioning process which has clearly not happened to date. GPs ought to be in a good position now to ensure that this does happen.

35. GPs will need to become active participants and information providers to Local Healthwatch and there should be consideration given by the Department of Health to providing incentives for them to do so.

28. A duty of candour should apply not only to clinicians but to organisations. Patient safety and the improvement of care should be foremost in such considerations.

29. Effective public involvement in the managements of hospitals and in the system more widely depends upon those organisations built for that purpose (whether LINKs or Healthwatch) being properly funded, organised and the members trained.

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36. The Inquiry may wish to consider the following possible conclusions and recommendations in respect of the evidence relating to the patient and public involvement bodies.

37. Leaving aside the controversy between Mr Deighton and the forum leadership, the forum's approach to the Trust's A&E shows the limitations of what a non-expert body of volunteers can achieve in scrutinising a body as relatively complex as the Trust. The real danger in A&E lay not in poor hygiene, but in understaffing and a lack of governance/learning/training. But the forum's focus, particularly during its inspections of the Trust, was on the easier-to-understand issues of cleanliness and hygiene.

38. The fact that the forum's members were not able to understand the Trust in all its complexity might have been less important if the forum had made a concerted attempt to find out about patients' experience of the Trust, but there was little evidence that they did. The clear lesson is that patient and public involvement in the affairs of a body such as the Trust is unlikely to be ensured merely by forming a committee of members of the public who have from time to time been patients. There must be real engagement between the community and patients and any public and patient involvement body. The body must be well publicised, open to participation by non-members and must constantly canvass patients for their views and experiences.

39. The joint failure of the forum and the overview and scrutiny committees to establish a close working relationship was a serious failing in the context of the post-2003 structure of local involvement in and scrutiny of health services. The forum should have been the channel for patient experience to the committees, but the evidence suggests that its role fell well short of this. Notwithstanding the references to a close relationship in the guidance documents for both bodies, there should have been a greater emphasis placed on the integration of their functions.

40. There was a clear power imbalance between the Trust's patients' forum, an organisation of volunteers, many without healthcare sector or NHS experience, and the Trust. This appears to have resulted in the too great an emphasis being placed by the forum's leadership on the maintenance of the forum's relationship with the Trust. The Chairman may consider that the arrangements for any body charged with ensuring public involvement with the NHS needs to address this power imbalance and avoid such an emphasis.

Staffordshire LINk

41. The lack of prescription from the Department of Health as to the structure and constitution of LINks was a serious failing, notwithstanding the good intention behind it to create independent, non-bureaucratic local networks. In Staffordshire, uncertainty about the nature and role of the LINk meant that a disproportionate amount of time and resources were devoted to the establishment of governance and other procedures.

42. The local consultation process for the establishment of the LINk resulted in a structure that was unwieldy and ultimately unworkable – Nine committees covering Staffordshire with potentially 128 members, all to be administered by three or four part-time host employees. Although guidance or diktats from the centre might themselves have produced such a result, the right kind of guidance might have helped to avoid it. The Chairman may wish to consider recommendations dealing with the appropriate level of guidance from central government in establishing such bodies.

43. The LINk was clearly seriously under-resourced from its inception and for the whole of 2008-09. It was the responsibility of Staffordshire County Council and Staffordshire University as hosts to ensure that the organisation had sufficient support, but they failed to discharge this responsibility. The LINk members, however fractious, cannot be blamed for this.