It was the primary responsibility of our Trust and the Board to keep patients safe and care for them with dignity. We failed to do this. We let patients and their families down at the most vulnerable time of their lives because we did not manage as we should have done.

The purpose of this closing statement is to set out what we believe are the key areas where lessons can be learned from the tragic events at our Trust. They are as follows:

1. **Patient Safety (Zero Harm)**

   It is our duty to keep people safe when they are in our care. One of the five key themes of our Trust has been “zero harm” to patients. This should be the most basic rule of any healthcare organisation.

   To achieve zero harm it is vital not to lose sight of the human impact of poor treatment. When we get it wrong we must focus on that particular patient’s poor care and look and learn from what we are not doing well to ensure that it does not happen again. By way of example, I recently attended a meeting where one of the issues related to the “Liverpool Care Pathway”. This is a care pathway designed for patients who are nearing the end of their lives. The statistics presented showed that 98% of patients went through the Liverpool Care Pathway. On the face of it, this looks good, but what this really means is that 2% did not get the correct care plan. In fact, that 2% represented four patients where we had got it wrong. We must focus on these four patients to determine why we got it wrong and what we can do to improve, and not only focus on the 98% of patients where we got it right.

   We must also develop indicators of a healthy culture. A good indicator is how we care for the most vulnerable patients; the frail, the elderly and those with learning disabilities. If we get it right for them, we will get it right for all our patients.
In his evidence Sir Bruce Keogh (Tuesday 20th September, day 125, page 199, line 17) said: “…in terms of really developing quality in the NHS, there needs to be a significant focus on professionalism.” and we agree. Where individual clinicians fail to treat and protect patients to the best of their abilities then Trusts must be empowered to remove them. The Inquiry now knows how difficult it is to remove a poorly performing doctor and we need to address this position to ensure that poor doctors are not protected at the expense of patient safety.

Individual clinicians (and non clinicians) of all professional backgrounds must be committed to ensuring quality care from the very root. If they see examples of poor practice then they must speak out. It is their professional responsibility to do so and employers have an important role in making these expectations clear while ensuring the organisational culture supports them to do so. An effective whistleblowing policy is essential but organisations must establish further systems to ensure that staff can access the appropriate mechanisms to speak out.

2. Compassion Matters

Good quality is not just about getting patient safety and clinical outcomes right, we must also get patient experience right, we must protect patients dignity and treat them with respect and compassion.

Evidence from the Prime Ministers Commission on the Future of Nursing 2010 makes it clear that, above all, the public want compassion from their NHS staff. Compassion and kindness is not just about doing the right thing but making sure that we have people within the NHS with the right skills and aptitude to do it. We are here to care for the public and compassion really matters. It is up to the NHS to ensure that it employs people with the right values, behaviours and skills. These values should be tested as part of the selection process for NHS staff e.g. by some form of assessment testing. The same applies to students applying for entry to train as a healthcare professional.

How to treat patients with genuine care and compassion should feature in the educational curriculum for all healthcare professionals. It should not be optional or taught
in isolation, it should be an integral part of everything that we do from the moment we enter training.

We need to ensure that there are role models within our hospitals, like the empathetic Ward Sister who maintains high standards and acts as a mentor for junior nurses. We need to move away from the ‘no blame culture’ to a ‘just culture’ where staff are clear about their responsibilities and accountable for their actions.

We need to develop our senior nurses. Ward Sisters who will not accept anything less than the best standards of care should be encouraged and rewarded to stay at that level rather than moving into more senior roles.

3. **Best Practice Systems**

Today, each Trust is left to develop its own procedures. To ensure quality and consistency the NHS should produce best practice models that can be adapted to meet local circumstances where appropriate. These are vital in relation to a number of areas such as clinical governance and HR policies and procedure. There is however, no point in having good systems and practice models unless they are properly implemented through training; empowering staff to have the confidence to challenge poor quality. In her evidence, Trudi Williams described how clinical governance teams are staffed by nurses who have received little or no training in clinical governance and who have learned about clinical governance through their own experience and no doubt by the mistakes made. Helene Donnelly, told the Inquiry she was unaware of the Trust’s whistleblowing policy, despite its existence, because it had not been properly implemented through training and staff had not been made aware of its existence. Indeed Mid Staffs often got the paperwork right but failed on the implementation.

4. **Organisational Culture**

Systems and processes are not enough in themselves to avoid problems and they do not save lives. It is of course important to get systems and processes right but that in itself is not enough and we still let people down if we have ineffective leadership, values
and teamwork. Organisational development is still not universally seen as a priority for the NHS and is not given the profile it deserves as an important factor in protecting patient safety. Andy Burnham told the Inquiry (Tuesday 6th September, day 115, page 71, line 3) that “politicians on all sides make a mistaken judgment that organisational, structural change automatically lead to higher standards” and that is absolutely right; changing the structure does not make any difference to the patients on the wards. We need to ensure that the NHS understands this and that organisational processes still let people down, no matter how advanced they might appear. Again, we need to look at the human impact of everything that we do and there is a growing recognition within the NHS that human factors should be an integral part of the developing patient safety agenda.

The culture of denial at Mid Staffs was very hard to change and from our experiences we are not sure there is an easy way to tackle it. Denial is embedded within the NHS and there is undoubtedly a tendency to defend our actions to the media and the public. Promoting a more honest and open culture right through the core of the NHS will help tackle the problem and then it is down to each organisation to ensure a culture of denial does not become embedded within it.

Much can be said for the role of training and support at all levels as a way to tackle a dysfunctional organisational culture and we encourage a system whereby newly appointed managers can contact their contemporaries if they need advice or there are any problems.

We need to provide people with the help and support to deliver the service. But where do you draw the line between asking people to do their jobs and bullying and harassment? The simple truth remains that there were many people within Mid Staffs who knew what was going on and they did absolutely nothing. It is the job of the managers and leaders to provide staff with the tools to do the job but then to hold them to account if they fail.
5. Local Accountability

The NHS needs to understand that being held to account by the media and local groups is a good thing and should be valued. We have learned at Mid Staffs of the value of ‘Cure the NHS’ and of the local media in highlighting problems. They are tough and critical and they insist on only the best care and standards. They hold us to account and insist on improvements and this should be embraced.

The NHS must support and encourage accountability through the local community; whether it is via patients, their families, support groups or the media.

It has been said on more than one occasion during this Inquiry that complaints are like gold dust. We must be transparent around complaints so that we can learn from them and so that the public can truly hold us to account.

6. The Trust Board – the buck stops here

The Trust Board is responsible for the performance management of the Trust and must put safety and quality of care at the heart of everything that we do. Hospitals should have a whole systems model of performance management with the Board papers linking all the issues of performance together.

For the Board to be effective and for its own performance to be effectively scrutinised, the Governors and Non Executive Directors must play a key role and satisfy themselves that all actions the Board takes will achieve the Trust’s primary purpose of protecting patient safety and that the Board are capable of delivering it. Governors and Non Executive Directors should be trained to know how to properly scrutinise and challenge.

More work needs to be done on the role of Governors around accountability to the local population. It is vital that the Council of Governors are independent so that they are free to influence and challenge the Trust from the perspective of the local population and not to simply reaffirm everything that a Trust decides.
It is essential that Trust Boards remain open. It is simply unacceptable that even today, in parts of the NHS, there continue to be closed board meetings. Whatever the reason they give, there is no reason good enough. We must be open and transparent in everything that we do, demonstrating that we are there to manage the public’s NHS.

At Mid Staffs we have open public meetings. We involve the public in the meeting and in the evaluation of the meeting. We make it clear that if they want to raise anything then they can. Of course there must be a closed part of the meeting where commercial confidential or personal data is discussed. However, we ensure that the public know what is covered.

We firmly believe that it is also important to discuss mortality issues, incidents, complaints and patient stories at Trust Board meetings to remind us about the human impact of everything that we do.

The Trust is now transparent and candid with patients when mistakes have been made. Our complaints process is open and we strive to include patients and relatives in every aspect of the process. We believe that our role is to support patients and their families while they are in our care, including if things go wrong, and we urge all Trusts to adopt a similar approach.

If the NHS is to move forwards and to learn lessons; the regulators and indeed the NHS as a whole, must be open and candid and recognise where mistakes have been made. We believe that communication and sharing of knowledge and information is crucial and is the first step towards true transparency.

7. Regulation and Development

Mature regulators should look for the best parts of their predecessors’ practice and build upon them. Valuable contributions and knowledge is being lost to the detriment of the NHS and patients. We need to ensure a sustainable regulatory system which can build on its strengths and truly hold providers to account.
It must be remembered that regulation is a means to an end, not and end in itself. Unfortunately, it has developed a life of its own. We desperately need clarity within the NHS on what each regulator is doing and there has got to be more focus on outcome and not just processes.

In our view there is a case for one regulator responsible for both financial and quality regulation. Finance and quality are interdependent and impact directly upon each other. To separate these out, leads to inevitable gaps in knowledge and practice. It seems to us a model where there is one main regulator with two separate arms for finance and quality, which pools that knowledge at the end of the process would, in the Trust’s experienced opinion, seal the gaps which exist.

We must avoid knee-jerk and unhelpful responses from the regulators where there is a declaration of non-compliance. To do so is “bayoneting the wounded”, a phrase we have heard during the course of this Inquiry. When a Trust is in difficulty it needs help, not to be pilloried. Whilst we recognise that sometimes, being interventionist will be the only way to force changes, from our experience at Mid Staffs, it felt like there were too many people telling us what was wrong but no one offered us any help. In our experience it seems that regulation is full of commentators; some who watch, give opinions and are critical of what they see. Support or help is rarely offered. In his third witness statement Antony Sumara surmised that regulators “are not players in the team; they are critics like fans watching a football match” and I would agree. We believe that there may well be a place for a regulator that not only regulates performance and holds Trusts to account but also has a role in assisting the organisation in developing its performance.

**Closing**

We owe it to the local community in Stafford for the whole of the NHS to learn from the recommendations of this Inquiry. Every level needs to reflect and improve.

It is dreadful that the NHS has not learned from its past failures and this time, it is vital that lessons are learned and we see a national drive and progress. This is the last chance to get it right. It is important for the Inquiry to consider how best to communicate
its recommendations so that they reach all NHS staff at all levels. At our Trust, the video produced from the Independent Inquiry had a profound effect on our staff.

We have got to be more aware of the impact that we have on people’s lives when we get things right and when we get things wrong. This is not our NHS, this is the public’s NHS. We are the custodians on their behalf and therefore it is important that they should be allowed to get involved in what we do.

Real improvements are only going to be delivered by front line staff and whatever we do now needs to impact the front line through training, support and development.

This is a rare opportunity to make meaningful changes to the NHS to improve patient care and we believe that openness, transparency and clear values focussed on individual patients is the key to a safe and caring NHS.