

Trust Board Meeting: Wednesday, 13 March 2013
TB2013.39

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| Title | Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry |
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| Status | This paper provides a summary of the key findings of the Francis Report and updates the Board on the initial actions taken within the Trust. |
| History | This is a new paper. |

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| Board Lead | Professor Edward Baker, Medical Director | | | |
| Key purpose | Strategy | Assurance | Policy | Performance |

Summary

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| 1 | Robert Francis's second report on the failings at Mid-Staffordshire NHS Foundation Trust (the Public Inquiry) was published on 6 th February 2013. The report focuses upon the response of the wider health system to concerns about quality at the Foundation Trust. |
| 2 | The story told in the report has important lessons for the OUH and for the wider NHS. The overarching theme is of a negative NHS culture resistant to criticism and not putting the care and safety of patients first. |
| 3 | Francis makes 290 recommendations which, if implemented, will have a major effect on the future of the NHS. |
| 4 | Some of the recommendations have significant implications for the OUH. Some of the lessons from the Inquiry and the initial implications of the recommendations are presented in this report. |
| 5 | The Government has said it will produce a full response to the report during March 2013. |
| 6 | A series of open staff briefings has been held in order to discuss the key topics addressed by Francis in his two reports. The briefings were led and facilitated by Dr Ian Reckless assisted by the communications team. |
| 7 | A total of 11 briefings were held between Monday 18 th February and Thursday 28 th February. In addition, two further briefings were embedded within meetings of the Trust Clinical Governance Committee, and the Acute General Medicine Governance Forum. Briefings occurred on all four sites. |

Board Lead

Professor Ted Baker

Medical Director

Background

1. The Healthcare Commission published a report of an investigation into the care provided at Mid Staffordshire NHS Foundation Trust in March 2009. The first inquiry by Robert Francis QC into the care at the Trust was published in February 2010. On the 6th February 2013 the Public Inquiry into the Mid Staffordshire NHS Foundation Trust (MSFT), also chaired by Robert Francis, was published.
2. The Healthcare Commission investigation into the MSFT was initiated because of two principal concerns. Firstly, the MSFT had a number of mortality alerts in a short period and failed to respond adequately to the Healthcare Commission's enquiries about them. Secondly, the Healthcare Commission received a high number of complaints about poor standards of care at the MSFT.
3. The Healthcare Commission report and the first Francis report focused on the care provided to patients in the MSFT. Particularly powerfully the first Francis report was built around patient stories, where the inadequacies of care provided to individual patients were made very clear.
4. The Public Inquiry has addressed the wider issues of management and culture within the NHS, examining in great detail the governance of the MSFT, PCTs, the SHAs and the Department of Health. It has examined the actions and culture of a variety of regulatory bodies, including the Care Quality Commission (CQC) and Monitor.
5. The first two reports shocked staff working across the NHS and raised serious questions about professional standards and frontline leadership. Oxford University Hospitals NHS Trust (OUH) has responded to this by building a new clinically led management structure and with our Delivering Compassionate Excellence programme. We have re-built our governance structure, launched an ambitious quality strategy and through our staff engagement programme, Listening in Action, we have promoted cultural change based upon our declared values.

The Report of the Public Inquiry

6. The Public Inquiry report details the management processes at every level in the NHS, from the MSFT to the Department of Health and finds them wanting. It portrays a hierarchical culture, often perceived as bullying and frequently ineffectual in dealing with problems. Francis describes "*staggering complacency*" about clinical failure and "*a culture of tolerance*" of poor standards and is critical of the "*defensive institutional instinct to attack those who criticise*".
7. It is not clear whether this is Francis's intention, but the forensic detail with which he examines every level of system gives the overarching impression of a self-serving bureaucracy that has completely lost contact with its purpose, to provide high quality care for patients.
8. This point is perhaps no more clearly made than in Francis's comprehensive description of the foundation trust authorisation process where he notes that the

process examined in detail every aspect of the MSFT's performance with the one exception of its ability to provide satisfactory care for patients.

The Mid Staffordshire NHS Foundation Trust

9. The depiction of the MSFT is of an organisation in constant crisis that is never on top of its agenda. Pursuing authorisation as a foundation trust became the priority and the sole measure of success, while serious clinical issues were not being addressed.
10. The biggest clinical concern was the understaffed and poorly led accident and emergency department. The MSFT's focus was purely on the achievement of the four hour emergency access target. This approach led to intense pressure on frontline staff which made the clinical problems worse. When whistleblowers raised concerns the MSFT responded by initiating long-winded human resources processes that eventually led nowhere.
11. The MSFT was aware of significant nursing staff shortages across many of its wards, but took eighteen months to produce a report and propose the action necessary. It knew from a report by the Royal College of Surgeons about its dysfunctional surgical department, but failed to act. Francis is withering in his criticism of the MSFT for its failure to focus first and foremost on clinical quality and to recognise and act on the many warning signs of the clinical problems. An example of this is the MSFT's response to an adverse inpatient survey.

"The Board was made aware of the 2006 survey figures at the meeting on 3 May 2007 when it was reported that the Trust was in the worst 20%. Predictably, an action plan was said to have been developed."

12. The MSFT failed to listen to the substance of patients' complaints. The complaints system concentrated on delivering (and in practice often failing to deliver) a complaints process, rather than learning from complaints and identifying clinical problems. The Board was not self-critical. It believed positive stories about the clinical care it provided, but disregarded or explained away negative information, whether it was complaints, patient or staff feedback, external reports or mortality alerts.

Culture

13. Francis says a fundamental change in culture is needed. The culture of the NHS should be to put patient care and patient safety first. In the report he describes weaknesses throughout the current NHS culture.

"Aspects of a negative culture have emerged at all levels of the NHS system. These include: a lack of consideration of risks to patients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions of trust, acceptance of poor standards and, above all, a failure to put the patient first in everything done. The emergence of such attitudes in otherwise caring and conscientious people may be a mechanism to cope with immense difficulties and challenges thrown up by their working lives."

14. While he devotes much of his report to the cultural issues and emphasises the need for cultural change, Francis's analysis never identifies a root cause of the broken culture in the NHS that led to the Mid Staffordshire failures. Therefore his solutions are general rather than specific. At times he accepts that cultural change will be difficult to deliver, but his recommendations focusing on leadership, values, candour and fundamental standards attempt to bring about a major cultural renewal.
15. One of the means by which he seeks to change culture is by statute. In his recommendations Francis proposes that there should be four new criminal offences.
 - 15.1. An individual and corporate offence of causing serious harm or death as a result of breach of new 'fundamental' standards.
 - 15.2. An offence of breaching a statutory duty of candour.
 - 15.3. An offence of making false statements in quality accounts.
 - 15.4. An offence of knowingly obstructing another in the performance of these statutory duties.
16. It is not clear whether creating new criminal sanctions will improve the defensive culture of which Francis is so critical in his report. Certainly he had unequivocal advice in evidence to the Inquiry that this might be counter-productive. Francis rejects this advice in favour of his assertion of the need for "zero tolerance" of failure to deliver basic standards of care.

Recommendations of the Public Inquiry

17. The report sets out a total of 290 recommendations. Francis identified five themes in the recommendations and the main recommendations are summarised under these headings below.
18. A structure of fundamental standards and measures of compliance.
 - 18.1. There should be a set of clearly understood core values and fundamental standards embedded in a strengthened NHS constitution.
 - 18.2. The fundamental standards should be easily understood and accepted by patients, the public and healthcare staff, breaches of them should not be tolerated. They should be rigorously enforced.
 - 18.3. NICE should develop standard procedures for measuring compliance with the fundamental standards. Providers who cannot meet these standards should not provide the service.
 - 18.4. The standards should be enforced by the CQC which should become the single regulator dealing in addition with corporate governance, financial competence, viability and subsuming the functions of Monitor.
 - 18.5. The CQC should have power to prosecute where fundamental standards are breached.
 - 18.6. Commissioners should be given an enhanced role in assessing provider quality. They should develop enhanced quality standards above and beyond the fundamental standards and enforce them contractually. Commissioners will have the final say in the quality required, but delivery of the standards will

depend on the appropriate resources being made available. Commissioners should also agree long-term developmental standards with providers.

19. Openness, transparency and candour throughout the system underpinned by statute.

- 19.1. There should be a statutory duty of candour. Patients must be told when something goes wrong with their care. It should be a criminal offence to mislead a patient or concerned relative about a clinical incident.
- 19.2. Staff should be obliged to tell employers about incidents that might cause harm to patients. Misleading commissioners or regulators or making false statements in trust quality accounts should also be criminal offences.
- 19.3. New rules will govern the release of information to Coroners. Transparency between different regulators and between them and Coroners should be increased.

20. Improved support for caring, compassionate, and considerate nursing.

- 20.1. There should be changes to nurse training to make it more practically based. Recruitment to the profession should change to ensure those entering training have the right values.
- 20.2. Nursing leadership at ward level should be enhanced.
- 20.3. There should be enhanced annual appraisal for all nurses. There should be responsible officers for nursing and a process of revalidation for nurses should be considered.
- 20.4. A new specialism in older person's nursing should be considered.
- 20.5. There should be common standards of training and registration for healthcare support workers.

21. Stronger healthcare leadership.

- 21.1. An NHS leadership college should be created. Senior managers should be trained in ethics.
- 21.2. There should be a "fit-and-proper" test for directors of providers who must comply with a written code of conduct. Clinical failure of a service or organisation should be grounds for disqualification of a director.
- 21.3. NHS complaints handling should be improved. The access to the system of making a complaint should be simplified for patients. They should have access to better support and independent clinical advice.
- 21.4. Commissioners should be more involved in the complaints process with access to all the information about individual complaints, undertaking their own investigation where necessary.
- 21.5. Trusts should publish more details of individual complaints on their websites.
- 21.6. The role of foundation trust governors should be extended. Monitor and the CQC should publish guidance to help governors understand what is expected and should provide advice to them on whether trusts are failing in relation to

healthcare standards. The guidance should cover how governors communicate with and represent the general public as well as members.

22. Accurate, useful and relevant information.

- 22.1. There should be clear widely used metrics on clinical quality.
- 22.2. The NHS Information Centre should independently collect, analyse and publish healthcare information.
- 22.3. Each clinical service must publish real-time data on patient safety and compliance with minimum quality standards.
- 22.4. Each provider should have a board member with a responsibility for information.

Immediate issues for OUH to consider

23. The first of Francis's recommendations is directly relevant to OUH. It recommends that:

- 23.1. All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;
- 23.2. Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;

24. Culture

- 24.1. The overarching finding of the Public Inquiry report is that there needs to be a radical change in culture within the NHS. The OUH needs to consider whether the work already underway is sufficient to meet the expectations of this report.
- 24.2. The importance of leadership and clinical engagement are stressed in Francis's conclusions. OUH should consider reviewing its current programme of leadership development to ensure that lessons of the MSFT story are incorporated into it.

25. Complaints

- 25.1. The failure to listen to patients was one of the fundamental errors of the MSFT. In the light of the criticism of complaint handling in the report, the OUH should consider whether its complaints handling process needs revisiting.

26. Risk management

- 26.1. Francis has identified a "regulatory gap" in which clinical incidents are dealt with on a statutorily different basis from health and safety incidents. By introducing a new criminal offence of causing death or serious harm as a result of the breach of fundamental standards of care he is seeking to close that gap. If this is

enacted our approach to managing clinical risk will have to change to one comparable to that for health and safety.

27. Mortality

- 27.1. While much of the publicity about the failures at the MSFT has focused on avoidable mortality, the chapter on mortality measurement in the Public Inquiry report is perhaps the least satisfactory. This probably reflects Francis's frustration that much of the debate is about the statistical methods rather than the clinical care of patients.
- 27.2. The OUH has initiated a process of comprehensive review of all deaths to identify improvements in care. This needs to be given priority in our clinical quality work programme.

28. Response to quality concerns

- 28.1. Francis is extremely critical of the MSFT's slowness in recognising and responding to clinical concerns. OUH should review how it responds once a concern is raised to ensure that it is investigated and effectively addressed rapidly.

Government response

29. The initial Government response has been to signal that there will be a single failure regime for hospitals with boards held accountable for failures in clinical quality.
30. The Friends and Family test results will be used to trigger immediate inspections of hospitals.
31. Don Berwick, former president of the Institute for Healthcare Improvement in the USA, has been asked to advise on how zero harm can be made a reality in the NHS.
32. The relationship and powers of the Health and Safety Executive and CQC will be reviewed.
33. There will be a new inspection regime for hospitals led by a Chief Inspector of Hospitals based in the CQC.
34. Ann Clwyd MP and the Chief Executive of South Tees Hospitals NHS Foundation Trust, Tricia Hart, have been asked to advise on how NHS hospitals can improve handling of complaints.
35. The Government will make a full response during March.

Staff briefings at OUH

36. A series of staff briefings have been undertaken since the publication of the Public Inquiry report. Briefings took the form of a presentation (see appendix 1) followed by an opportunity for staff to comment, share reflections and ask questions.

37. Approximately 750 members of staff attended the briefings. The audience was multidisciplinary on all but one occasion (nursing only). In general, discussion was free flowing and staff members made thoughtful and well considered contributions. Staff of all professional backgrounds and various levels of seniority made contributions.
38. It was made clear to staff that it might not be possible to tackle issues brought up at the briefings there and then. It was agreed that some of the issues raised would need to be considered in other settings. A commitment has been made to share the organisation's response to these issues with staff in due course.
39. There was consistency in the issues highlighted by staff in the course of the briefings, and there was little dissent between those choosing to speak.
40. The issues raised are described in Appendix 2 in the following eight categories:
 - 40.1. Feedback – gathering and using information at service level
 - 40.2. Training – profile and priority
 - 40.3. Financial constraints
 - 40.4. Leadership and empowerment
 - 40.5. Nursing – changes in shift patterns
 - 40.6. Staff – numbers and skill mix
 - 40.7. Staff – valuing contribution
 - 40.8. Staff – agents for change
41. It is proposed that a small working group led by Executive Directors should be established to agree how to respond to this feedback and develop the Trust's response to Francis going forward.

Recommendations

42. The Board is asked to:
 - 42.1. note this summary of the Public Inquiry into the Mid Staffordshire NHS Foundation Trust;
 - 42.2. comment on the findings and recommendations of the Inquiry;
 - 42.3. note and comment on the issues highlighted for immediate action;
 - 42.4. note the staff engagement work already underway and the proposed next steps.

Professor Ted Baker
Medical Director

Appendix 1
Presentation for Francis Briefing Sessions




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Mid-Staffs

The Francis Reports and what they might mean for OUH




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Agenda

1. The Mid-Staffs Story
2. Findings and recommendations of two inquiries chaired by Robert Francis QC
3. How did Mid-Staffs happen?
4. What does it mean for us at OUH?



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Between 400 and 1200 people died in excess of the number that *might* have been expected

Between 2005 and 2008 conditions of appalling care were able to flourish in the main hospital serving the people of Stafford and its surrounding area...

Foundation Status achieved in February 2008




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Mid Staffs


OBSERVATIONS AND CASE STUDIES



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- Patients were left in excrement, in soiled bedclothes, for lengthy periods
- Assistance was not provided with feeding for patients who could not eat without help
- Water was left out of reach
- In spite of persistent requests for help, patients were not assisted in their toileting



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- Wards and toilet facilities were in a filthy condition
- Privacy and dignity, even in death, were denied
- Triage in A&E was undertaken by untrained staff
- Staff treated patients and those close to them with what appeared to be callous indifference




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The story of a grandmother...




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Her daughter told me how her mother experienced severe diarrhoea, and on one occasion when she visited she could not find a nurse to help clean her mother. *“... There was not a nurse around, there was not a doctor around. I looked for so long, it was a good half an hour, and there was nobody anywhere. So in the end, I got some rubber gloves and started to clean my Mum myself...”*



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“... At that point one of the nurses said: your Mum is highly contagious and you should not be cleaning her. I said: where are you; I need some help here, I can't leave my Mum sitting in her own faeces in a ward with visitors and everybody watching her.”



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The story of a 67 year old man...



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On his admission to the Emergency Assessment Unit, his wife recalled that he was not given a pillow, and for two days he had to use a rolled-up blanket instead. His wife was initially told that she could bring in pillows for her husband; however, when she did so the ward sister refused to allow him to use them. She later provided him with a single pillow that had been taken from another patient.



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In the final stages of his illness her husband was not given any oral care, and she recalled that his mouth was in a *“dreadful mess”*. She had to ask for oral packs and attend to him herself. At this time, she noted that it was *“extremely distressing and difficult to do this for him”*.



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She concluded her correspondence by stating that her *husband* “was a good man, a gentle man, who struggled with his disability and his lack of mobility for more than 16 years without complaint. He did not deserve to end his life in such an undignified manner and in such distressing circumstances.”



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The story of a 96 year old lady...



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A woman arrived at 10am to see her 96 year old mother-in-law “completely naked... covered in faeces... It was in her hair, her nails and on the cot sides. It was literally everywhere and it was dried”.



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Mid Staffs
FINDINGS



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- There was a **lack of basic care** across a number of wards and departments...
- Management thinking... was dominated by **financial pressures and achieving FT status**, to the detriment of quality of care.
- There was a management failure to remedy the **deficiencies** in staffing and governance that **had existed for a long time**...



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- There was a **lack of urgency** in the Board's response to some problems...
- Statistics and reports were preferred to **patient experience data**...
- There was a **lack of internal and external transparency** regarding the problems that existed at the Trust



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- The culture at the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff; there was an **atmosphere of fear** of adverse repercussions; a high priority was placed on the achievement of **targets**; the **consultant body largely dissociated itself from management**; there was low morale amongst staff; there was a lack of openness and **acceptance of poor standards**.



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- A great number of people and organisations had been **aware of problems** at Mid-Staffordshire. Whether through a lack of co-ordination, a lack of skill or a lack of willingness – **the system did not take decisive action**.




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The second of two major inquiries, a Public Inquiry chaired by Robert Francis QC, reported on 6th February 2013

164 witnesses gave oral evidence
352 individual witness statements
Over a million pages of raw material reviewed



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The Public Inquiry

RECOMMENDATIONS
NOW BEING CONSIDERED



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290 recommendations of which 21 are highlighted in the following slides, set out in 7 categories:

- I. The NHS as an overarching institution
- II. Professionalism & Professional Regulation
- III. Regulation of the NHS
- IV. Within NHS Trusts
- V. Senior Managers and Board Members
- VI. At Ward Level
- VII. Individual Members of Staff



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The NHS as an overarching institution:

- Expectations derived from the constitution
- A real focus on standards



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Professionalism & Professional Regulation:

- Focus in nurse training on practical rather than theoretical aspects
- National entry level requirement of at least three months working in direct patient care
- Appraisal and revalidation for nurses
- Regulation of healthcare support workers





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Regulation of the NHS:

- A single regulator
- Inspection not self-assessment
- Zero tolerance of clear failure
- Local Councils to have a power to inspect providers



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Within NHS Trusts:

- Publish complaints and responses to them
- Seek feedback from students and trainees
- English language test for medical staff
- Death certification the responsibility of Consultants





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Senior Managers and Board Members:

- False statements as to compliance with standards should be made a criminal offence





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At Ward Level:

- Senior clinician responsible for care ('name above the bed')
- Patient discharge – *not acceptable for patients to be discharged in the middle of the night*
- Ward managers supervisory
- Every patient to have a named nurse, present at every interaction with a doctor



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Individual Members of Staff:

- Employers to insist that staff report incidents of concern – staff entitlement to receive feedback
- Criminal liability for professional staff in relation to openness and transparency




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Mid Staffs

HOW DID MID STAFFS HAPPEN?



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Optimal **Acceptable** **Unacceptable** **Criminal**

← *A spectrum of care quality...* →



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Optimal **Acceptable** **Unacceptable** **Criminal**

- Do you ever witness care on the margin between acceptable and unacceptable?
- Have we grown used to sub-optimal care over the years (has such care become 'normalised')?



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Did these people set out to neglect and abuse those in their charge when they took up posts?



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Staffordshire
NHS Foundation Trust

Did these people set out to neglect and abuse those in their charge when they took up posts?






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- The culture at the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff; there was an atmosphere of fear of adverse repercussions; a high priority was placed on the achievement of targets; the consultant body largely dissociated itself from management; there was low morale amongst staff; **there was a lack of openness and acceptance of poor standards.**

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Do we always see the person in the patient, however busy and stressed we might be? Do we ever step back?

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How would our students see things?





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Mid Staffs Reports

WHAT DO WE NEED TO DO?



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What do WE need to do?

- Reflect on our own clinical environment
- Advocate for patients, all day, every day
- Engage in management and service improvement
- Talk about the quality of care, with colleagues and with line managers




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What do WE need to do?

- Use incident reporting and other governance mechanisms wholeheartedly
- Don't stop championing a care quality issue until your concerns have been appropriately considered or addressed (mindful of the wider resource challenge)

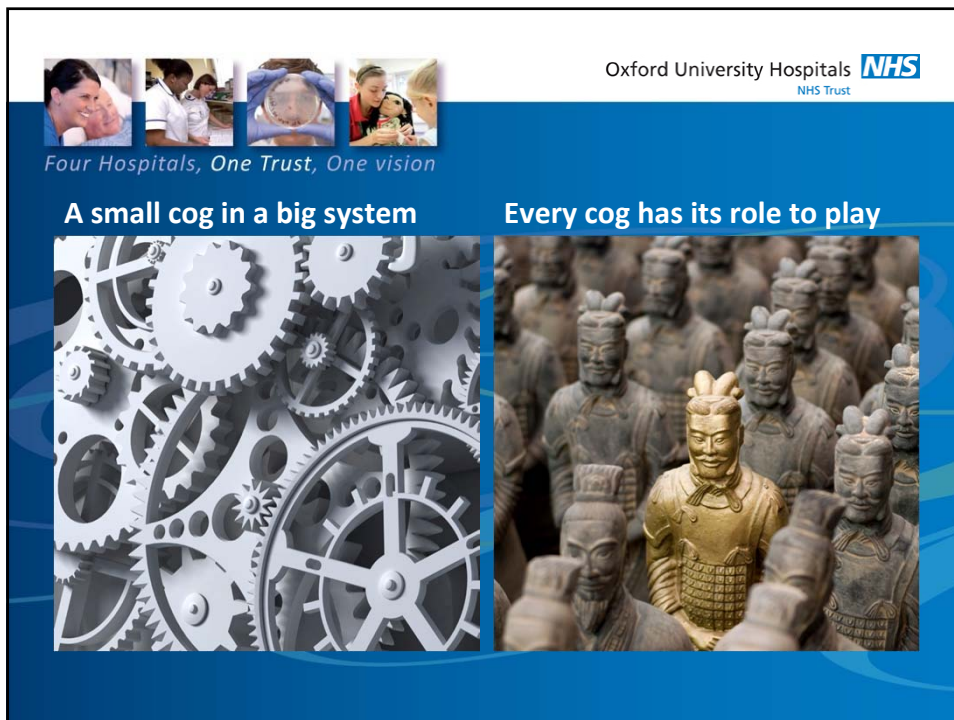
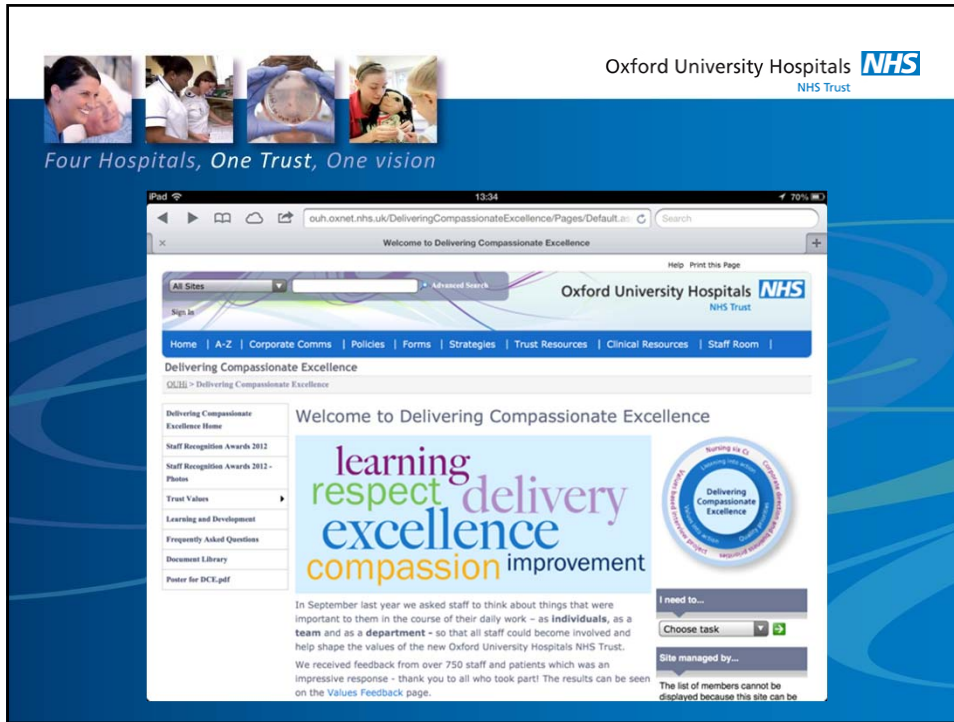


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What do WE need to do?

- Work together to minimize waste
- Each and every one of us is responsible for the quality of the care provided
- When issues are identified, each one of us needs to become part of the solution – rather than being a bystander (or part of the problem)



Appendix 2

Summary of issues raised by staff following open Francis Briefing Sessions

1. Feedback – gathering and using information at service level:

- Staff asked for more feedback of qualitative information on services (including complaints, PALS and compliments).
- Staff asked for more effective capture of the experience or opinions of trainees, students or peripatetic workers passing through various clinical areas as to the strengths and weaknesses of the care provided there. There was no desire for new systems, rather a wish to see ward managers and clinical leads actively seeking and acting upon such feedback.

2. Training – profile and priority:

- Recent progress with statutory and mandatory training was welcomed but many staff members felt that the profile and priority afforded to other forms of training should be higher (for example, staff asked for more effective team-based training following incidents or in relation to new medical equipment).
- Some staff members recognised the presence of a significant local training resource in the form of simulation but felt it could be used more extensively.

3. Financial Constraints:

- Some staff expressed the view that the financial environment was so tight that potentially valuable ideas 'never get off the ground'.
- Some staff pointed to missed opportunities for savings within the hospital environment – for example, in the procurement of resuscitation equipment.
- At a time of resource constraint, many staff felt that the balance between completing paperwork to evidence care, and the delivery of that care itself was currently wrong.

4. Leadership and empowerment:

- Some staff members wanted to see more medical engagement in the routine business and development of the Trust.
- Some staff expressed the view that managers sometimes seemed to expect the wider Trust to be taking a lead in matters that should be within their remit.
- Some staff members questioned whether managers and leaders in the organisation had the necessary time and training to lead as opposed to manage.
- Staff members emphasized the important place of peer review and buddying in the quality assurance and development of local services (advocating, for example, peer participation in internal CQC-style inspection).
- Some staff members emphasised the importance of role modelling at all levels in the organisation.
- Some staff members felt that risk registers should be shared more openly so as to raise their profile and credibility.

- Several staff members described line management structures that did not always seem to engage with challenging issues.

5. Nursing – Changes in Shift Patterns:

- Many participants expressed the view that recent changes to nursing shifts (reduction in the handover period) had had an impact. The specific observations below were made:
 - Morale and staff experience (ability to finish work on time, ability to deliver care that is personally and professionally satisfying);
 - Ability to maintain satisfactory documentation;
 - The experience of patients;
 - Patient care (face to face handover at the bedside offered an opportunity for care giving); and,
 - Staff training.

6. Staff – Numbers and Skill Mix:

- Some staff members expressed the view that agreed staffing establishments, particularly in respect of nursing, were lean.
- Staff highlighted the risk associated with the management and staffing of escalation beds.
- Staff pointed to the quality risks inherent to high levels of agency staff use.
- Many members of staff expressed frustration with the pace of recruitment processes within the OUH.

7. Staff – valuing contribution:

- Staff turnover was perceived as high in some areas.
- Staff reported that insufficient use is made of exit interviews.
- Staff reported a lack of band 2 development opportunities.
- Staff noted that we are poor at communicating the positive both inside and beyond the organisation.
- Some staff members reflected that the organisation's agenda and the agenda at service level do not seem to be aligned.

8. Staffing – agents for change:

- Staff recognised a deficiency in their own influencing skills in relation to the business aspects of the OUH (as opposed to individual patient care). Staff did not feel confident as to where in the organisation decision-making power lies. Staff recognised that problems may not be defined and articulated in terms that prompt engagement on the part of managers. Development of the skills and tools to enable staff to work collaboratively and to effectively seek out and influence decision makers was seen as an opportunity.