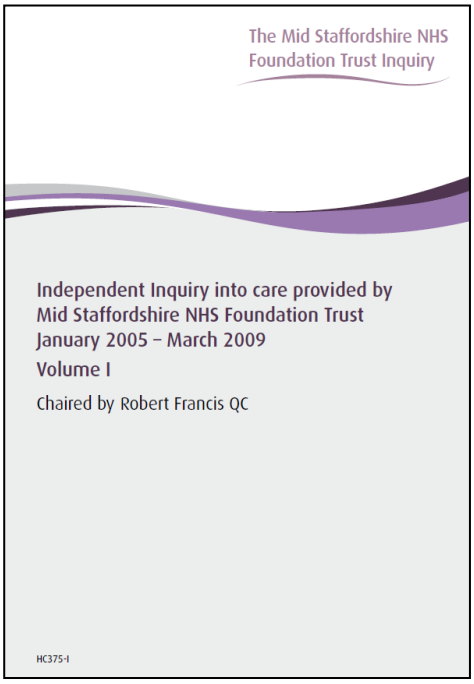
Mid-Staffordshire NHS – Operational Feedback

The Independent Inquiry into Care led by the Mid-Staffordshire NHS Foundation Trust (January 2005–March 2009) highlights the issues of systemic, managerial and cultural failure once more. There are thus clear parallels to be drawn with the Nimrod Review into the Afghan air crash of 2006, the Baker Panel report into the Texas City accident of 2005 and the Cullen report (Vol 1) (Vol 2) into the Ladbroke Grove train accident of 1999. As the summary below indicates, there are also serious lessons regarding customer care and communications from which we can all learn.

Learning points for the wider rail industry

This document contains learning points on:

- The importance of 'people over paper'
- The importance of risk and impact assessment
- The importance of adhering to standards
- The value of staff, and the risks arising from failing to support them
- The danger of focussing on systems at the expense of outcomes.



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Background

Concerns about mortality and the standard of care provided at the Mid-Staffordshire NHS Foundation Trust resulted in an investigation by the Healthcare Commission, which published a highly critical report

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on 17 March 2009. This was followed by two reviews commissioned by the Department of Health. These investigations gave rise to widespread public concern and a loss of confidence in the Trust, its services and management.

A three-month 'stock-take report' published in July 2009 concluded that there had been some progress, but that the net improvements were insufficient. The result was the establishment of a further independent inquiry, chaired by Robert Francis QC, to:

- 'investigate any individual case relating to the care provided by Mid-Staffordshire NHS Foundation Trust between 2005 and 2008 that […] causes concern';
- 'consider whether any additional lessons are to be learned beyond those identified by [earlier] inquiries'; and
- 'consider what additional action is necessary for the new hospital management to ensure the Trust is delivering a sustainably good service to its local population'. Back to top

Issues arising

The evidence gathered by the Inquiry showed that, for many patients, 'the most basic elements of care were neglected'. Calls for help to use the bathroom, for example, were 'ignored' and patients were 'left lying in soiled sheeting and sitting on commodes for hours, often feeling ashamed and afraid'.

Some staff 'were dismissive of the needs of patients and their families. '[T]his led to injury and a loss of dignity, often in the final days of [patients'] lives'. Staff also 'failed to make basic observations and pain relief was provided late or in some cases not at all'. Patients were 'too often discharged before it was appropriate, only to have to be re-admitted shortly afterwards. The standards of hygiene were at times awful, with families forced to remove used bandages and dressings from public areas and clean toilets themselves for fear of catching infections'.

'The deficiencies observed in the evidence were not confined to one ward or period. Frequently the explanation appears to have been a lack of staff, but sometimes staff were present but lacked a sufficiently caring attitude. There was evidence of unacceptable standards of care as a result of systemic failings. What has been shown is more than can be explained by the personal failings of a few members of staff'.

The Inquiry concluded that 'a number of the deficiencies at the Trust had existed for a long time'; whilst 'the executive and non-executive Board members recognised the problems, the action taken by the board was inadequate and lacked an appropriate sense of urgency'.

The Trust's board was found to be 'disconnected from what was actually happening in the hospital and chose to rely on apparently favourable performance reports by outside bodies such as the Healthcare Commission, rather than effective internal assessment and feedback from staff and patients'.

Problems at the Trust 'were exacerbated at the end of 2006/07 when it was required to make a £10 million saving. The Board decided this saving could only be achieved through cutting staffing levels, which were already insufficient. The evidence shows that the Board's focus on financial savings was a factor leading it to reconfigure its wards in an essentially experimental and untested scheme, whilst continuing to ignore the concerns of staff'. Back to top

What went wrong?

A long-term failure

The quality of nursing 'suggested that staffing levels had been acknowledged to have been too low as long ago as 1998'. There is evidence that 'financial issues were a concern at the Trust in 2004, if not before, when a vacancy scrutiny panel was set up; a plan for financial recovery had to be prepared in early 2005'.

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'Long-term habituation, denial, lack of engagement and commitment, and weak leadership, among other difficulties, are hard to change.' Back to top

Problems identified but not addressed effectively

'[M]any of the issues which were the cause of complaints made by patients and their families, as well as the concerns expressed by staff, had been recognised and been made the subject of action. Unfortunately, this was ineffective action.' Back to top

Confused view of responsibilities

'A constant theme from evidence about the Trust Board has been a retreat to the justification that its members were responsible for strategic and not operational direction'.

The Inquiry concluded that this 'is no excuse for not delving into the operational [side] during times when it was known that there were no governance structures in place or only developing ones. It should have been realised that until reorganisation was embedded and proved to be effective, it could not be relied on exclusively.'

'It was necessary for directors to roll up their sleeves and see for themselves what was actually happening.' Back to top

A lack of urgency

'Problems such as a lack of effective governance require urgent and comprehensive attention. They carry the necessary inference that safety and good practice are not assured, thereby prejudicing the interests of patients.'

The Inquiry concluded that '[i]t is unacceptable that a staff review, which was quite correctly commenced because of perceived staff and skills shortages, should take as long to complete as did the one initiated by [the Trust]'. Back to top

Figures preferred to people

The Inquiry noted that a 'common response to concerns has been to refer to data, often of a very generic type such as star ratings, […] and so on, rather than to the experiences of patients and their families'.

This is 'not to downgrade the importance of a collective and analytical approach to organisational assessment to draw attention to the only thing that really matters in a hospital – namely, individual patients'.

A 'high priority was placed on the achievement of targets, and in particular the A&E waiting time target. The pressure to meet this generated a fear, whether justified or not, that failure to meet targets could lead to the sack'.

The 'story of Stafford […]shows graphically and sadly that benchmarks, comparative ratings and foundation trust status do not in themselves bring to light serious and systemic failings'. Back to top

A lack of risk and impact assessment

'Significant changes have been seen to have been approved and implemented in the Trust without appropriate consideration of the risks involved'. While risk assessment 'has sometimes been referred to, little evidence of it actually occurring and being reported has been found'.

While there 'may have been some work at middle management levels, it is not an area that appears to have concerned the Board as much as it should have done. The Board seems often to have worked on the assumption that such matters were operational not strategic'. Back to top

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A focus on systems not outcomes

'While structures are an important and necessary part of governance, what is really important is that they deliver the desired outcome, namely safe and good quality care'.

There is evidence that 'systems predominated over improving actual outcomes for patients'. Back to top

Those who received care were not listened to

'Many of the complaints made to the Inquiry had already been made in precisely the same terms to the Trust.' Many of them, 'even if taken on their own as one person's observation, should have been enough to alert a listener to the existence of a serious systemic problem. Often the responses were formulaic. Even where they were not, the action taken as a result was inadequate.' Back to top

Staff disengaged from the process of management

First, '[s]taff expressed concerns, sometimes forthrightly and cogently, and were not listened to. […] These do not seem to have been addressed. Incident reports citing understaffing received no feedback'. Secondly, 'a culture in which staff separated themselves from management sometimes prevented a coherent staff view from being presented'.

There was 'evidence of consultants not just being reluctant to join in management […] but also of […] having little interest in the potential of such proposals to affect their own standards of service'. Back to top

Insufficient attention to professional standards

The Inquiry found evidence of 'a worrying acceptance of poor care, of poor behaviour among colleagues being condoned and of potentially dishonest behaviour being encouraged'.

Systems 'designed to improve performance, such as audit, appraisal and professional development, have been accorded a low priority by staff and management. Disciplinary processes seem to have been avoided even in manifestly serious cases'. Back to top

Lack of support for staff

Staff 'should not to have to contend with a culture of fear and bullying. Dedication, compassion and effective teamwork contribute to the welfare of patients and should be valued'.[1]

The 'constant strain of financial difficulties, staff cuts and difficulties in delivering an acceptable standard of care took its toll on morale and was reflected by absence and sickness rates in particular areas'. Back to top

A weak professional voice in management decisions

'The Board was entirely dependent for advice from qualified clinicians on the Medical Director and the Director of Clinical Standards/Nursing. Board members did not actively seek the views of the wider professional body on projects requiring this form of advice and input.' Back to top

A failure to meet the challenge of caring for the elderly and the vulnerable

'The Trust had a service for the care of the elderly but there has been little evidence of its contribution in many of the cases of concern reported to the Inquiry'. There was 'little evidence that there was a planned

[1] Staff described 'a forceful style of management (perceived by some as bullying) which was employed on occasion'.

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multidisciplinary approach to their care'. Back to top

A lack of external and internal transparency

The Inquiry saw 'evidence of a significant lack of transparency. Internally, feedback in relation to complaints and incident reports was often absent.'

Externally, 'the public was unnecessarily excluded from Board meetings, the degree of engagement with local bodies has been questioned, and in one serious case a report that should have been made available to the coroner was not sent'. Back to top

False reassurance taken from external assessments

The Board 'gained unjustified reassurance about the Trust's standard of performance from external assessments without taking into account the fact that most of these were based on information generated by the Trust itself. In any event, such reference points should not have discouraged them from fulfilling their duty to be aware of what was happening under their direction'. Back to top

A disregard for the significance of mortality statistics

'Too much comfort was taken from the coding as an explanation for concerning figures and insufficient consideration was given to other explanations.' Back to top

Recommendations *(reproduced verbatim from the Inquiry report)*

1 The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard.

2 The Secretary of State for Health should consider whether he ought to request that Monitor – under the provisions of the Health Act 2009 – exercise its power of de-authorisation over the Mid Staffordshire NHS Foundation Trust. In the event of his deciding that continuation of foundation trust status is appropriate, the Secretary of State should keep that decision under review.

3 The Trust, together with the Primary Care Trust, should promote the development of links with other NHS trusts and foundation trusts to enhance its ability to deliver up-to-date and high-class standards of service provision and professional leadership.

4 The Trust, in conjunction with the Royal Colleges, the Deanery and the nursing school at Staffordshire University, should review its training programmes for all staff to ensure that high-quality professional training and development is provided at all levels and that high-quality service is recognised and valued.

5 The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.

6 The Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this report and ensure that it:

- Provides responses and resolutions to complaints which satisfy complainants;
- Ensures that staff are engaged in the process from the investigation of a complaint or an incident to the implementation of any lessons to be learned;
- Minimises the risk of deficiencies exposed by the problems recurring; and
- Makes available full information on the matters reported, and the action to resolve deficiencies, to the Board, the governors and the public.

7 Trust policies, procedures and practice regarding professional oversight and discipline should be reviewed in the light of the principles described in this report.

8 The Board should give priority to ensuring that any member of staff who raises an honestly held concern about the standard or safety of the provision of services to patients is supported and protected from any adverse consequences, and should foster a culture of openness and insight.

9 In the light of the findings of this report, the Secretary of State and Monitor should review the arrangements for the training, appointment, support and accountability of executive and non-executive directors of NHS trusts and NHS foundation trusts, with a view to creating and enforcing uniform professional standards for such posts by means of standards formulated and overseen by an independent body given powers of disciplinary sanction.

10 The Board should review the management and leadership of the nursing staff to ensure that the principles described in the report are complied with.

11 The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on matters relating to the standard and safety of the service provided to patients.

12 The Trust should review its record-keeping procedures in consultation with the clinical and nursing staff and regularly audit the standards of performance.

13 All wards admitting elderly, acutely ill patients in significant numbers should have multidisciplinary meetings, with consultant medical input, on a weekly basis. The level of specialist elderly care medical input should also be reviewed, and all nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion.

14 The Trust should ensure that its nurses work to a published set of principles, focusing on safe patient care.

15 In view of the uncertainties surrounding the use of comparative mortality statistics in assessing hospital performance and the understanding of the term 'excess' deaths, an independent working group should be set up by the Department of Health to examine and report on the methodologies in use. It should make recommendations as to how such mortality statistics should be collected, analysed and published, both to promote public confidence and understanding of the process, and to assist hospitals to use such statistics as a prompt to examine particular areas of patient care.

16 The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified.

17 The Trust and the Primary Care Trust should consider steps to enhance the rebuilding of public confidence in the Trust.

18 All NHS trusts and foundation trusts responsible for the provisions of hospital services should review their standards, governance and performance in the light of this report.

Full report

The Inquiry's full report may be downloaded here: **LINK**

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