Delivery of Care in the Acute Setting: Lessons from the Mid-Staffordshire NHS Foundation Trust Inquiry

Robert Francis QC

Serjeants’ Inn Chambers
85 Fleet Street
London EC4Y 1AE
5 inquiries 1 hospital

- March 2009: HCC report
- Independent case note review
- Report on A&E [Sir George Alberti]
- Report on commissioning [Dr Colin-Thomé]
- July 2009: Independent inquiry announced
- 133 witnesses gave oral evidence
- February 2010: Report published: 2 volumes; 815 pages; +/- 900 experiences summarised
- 18 recommendations
And then...

• > 1 million pages of documentary material
• > 250 witnesses
• 139 days of oral hearings
• Terms of reference announced 9 June 2010
• Report handed to Sec of State 5 February 2013
• 1781 pages - 290 recommendations
• Costs: £13.684 million to March 2013
• Bloody Sunday Inquiry -- £192 million
It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm. It is quite necessary, nevertheless, to lay down such a principle, because the actual mortality in hospitals, especially in those of large crowded cities, is very much higher than any calculation founded on the mortality of the same class of diseases among patients treated out of hospital would lead us to expect. The
The people who matter..
One off or common?

Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report

Professor Sir Bruce Keogh KBE

CQC
National report on dignity and nutrition review published

13 October 2011
This review was a targeted inspection programme of NHS hospitals. It looked at whether older people are treated with respect and whether they get food and drink that meets their needs.
Some background
Who makes things better for patients – or stop things getting worse?

Ministers?

Permanent Secretaries?

Chief executives?

Regulators?

Commissioners?

Directors?

Inquiries?
Some experiences of “care”
Habituation? Tolerance?

“There was nothing uniquely dreadful to find out”

Q. It [the large number of people complaining about the same things] might be a reflection that the same sort of poor care was happening to a number of different people. Do you accept that?

A. I think it’s much, much more likely that the reason a huge number of people didn’t find anything uniquely dreadful is that there was nothing uniquely dreadful to find out.

Q. And that is still your belief?

A. Yes

Evidence of former Chair of Trust to Public Inquiry
So what was the fuss about?
*Training? Attitude? Leadership?*

She had got a cloth, like a J-cloth, and she cleaned the ledges and she went into the wards, she walked all round the ward with the same cloth, wiping everybody’s table and saying hello, wiping another table and saying hello. Came out of there, went into the toilets and lo and behold, she cleaned the toilets with the same cloth, and went off into the next bay with the same cloth in her hand. You can’t believe what you saw, you really couldn’t believe what you saw.
The daughter of a patient in ward 11

In the next room you could hear the buzzers sounding. After about 20 minutes you could hear the men shouting for the nurse, “Nurse, nurse”, and it just went on and on. And then very often it would be two people calling at the same time and then you would hear them crying, like shouting “Nurse” louder, and then you would hear them just crying, just sobbing, they would just sob and you just presumed that they had had to wet the bed. And then after they would sob, they seemed to then shout again for the nurse and then it would go quiet...
.. Abuse of the vulnerable?

The daughter-in-law of a 96 year old patient

We got there about 10 o’clock and I could not believe my eyes. The door was wide open. There were people walking past. Mum was in bed with the cot sides up and she hadn’t got a stitch of clothing on. I mean, she would have been horrified. She was completely naked and if I said covered in faeces, she was. It was everywhere. It was in her hair, her eyes, her nails, her hands and on all the cot side, so she had obviously been trying to lift her herself up or move about, because the bed was covered and it was literally everywhere and it was dried. It would have been there a long time, it wasn’t new.
Ignoring concerns
The investigation has found evidence of poor leadership and management and of poor nursing care on Ward 3 ... There is a strong view on the Ward that failings are due to the poor staffing levels and therefore excusable. The culture on the ward appears to allow for support of this view ... Nobody at directorate/Trust level appears to have taken responsibility for monitoring/auditing to ensure that basic nursing standards/patient care needs are met ... There appears to be a lack of commitment at the highest level in the Trust to tackle these problems.
A detailed investigation has been undertaken including obtaining information from 14 members of staff and considering a substantial number of documents. The following problems have been identified:

- failure to control diabetes
- failure to administer prescribed drugs
- failure to undertake nursing handovers properly or at all
- failure to complete nursing records adequately or at all
- failure to conduct medical ward rounds properly
- failure to make adequate or proper notes of ward rounds and care plans
- failure to give the patient a diabetic menu
- failure to report this matter as a SUI in a timely fashion
- failure to report to the Coroner
6. On arrival at Stafford I found the Emergency Department to be an absolute disaster. Its culture was unlike any other that I had worked in, despite being in the NHS for 25 years. There was a culture of bullying and harassment towards staff, especially the nursing staff. There was no evidence of an aspiration towards high quality patient care. There were clear clashes of ethos, ego, and basic philosophy. There was no significant medical leadership and fundamentally no vision of what “good” looked like. For a department to be effective, it is necessary for its leaders to identify what good care is and articulate it so that others know. The quality of care which we provided for people coming into the Emergency Department was way below the standard I would expect to aspire to and significantly below the quality provided in Stoke where I had been a few weeks before.
What a trainee doctor observed

- Insufficient nursing staff
- No effective nurse leader
- Managerial bullying of nurses to meet targets
- Capacity issues in wards
- Dysfunctional clinical leadership
- Proposed remedy of recruiting emergency physicians worse than cure
A dysfunctional surgical department

- Surgical Department dysfunctional and lacking effective leadership;
  - Colorectal department dysfunctional since 2003.
  - No working relationship between surgeons in the team:
    ... no cohesion within the department ... makes it very difficult for other members of the team to function in a satisfactory way
  - Multidisciplinary team meetings compromised by disagreement;
  - No departmental protocols on bowel preparation, antibiotic usage and postoperative management;
  - Surgeon had little or no insight into the problems over 4 years

Extract from RCS report October 2007. Public Inquiry report page 111-112

©2013 Robert Francis QC
RCS report two years later

- Poor judgement and decision-making
- Lack of current knowledge and suboptimal post-op care
- Some care “grossly negligent”.
- The surgical division “dangerous”
- Alternative to immediate urgent action was the closure of the department.

*The ... Report refers to so many badly managed cases that it would be difficult to single out any particular surgeon*

*RCS report 2009. Public Inquiry Report page 1027-1028*
Complaints

Case 5

126. The patient was admitted to EAU on 27 May 2005 following a fall at home. The family visited on 29 May 2005 to find extensive bruising to the patient’s forehead, right-hand side of the head and a cut to the right eye. The family believed that the patient had fallen but there were no incident forms to determine whether or not a fall had occurred in the EAU or if the injuries related to the fall at home. The action plan in response, on 22 January 2007 (following referral of the complaint to the HCC), stated that upon admittance to the EAU all patients would be assessed for risk of falls and that all staff would be trained in a new falls policy (which included notifying relatives when a fall occurred).

Case 6

127. The patient was admitted to the EAU on 19 January 2007 and family attended on 20 January 2007 to be informed that patient had fallen out of bed and hit his head. The complaint was made on 9 July 2007 and response was completed on 10 February 2008, including a statement in the action plan saying that all staff in the EAU would be instructed to maintain effective communication after a patient had fallen.

Case 7

128. The patient had fallen out of bed in the EAU and the family had not been informed. A complaint was made on 4 September 2007 and the response was completed on 8 October 2007, including an action plan that stated staff were to inform relatives when falls had occurred, should complete an incident report and utilise FRASE.
<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Admissions</th>
<th>Observed Deaths</th>
<th>Expected Deaths</th>
<th>Observed - Expected deaths</th>
<th>HSMR</th>
<th>95% CIs around HSMR</th>
<th>95% CIs around observed deaths</th>
<th>95% CIs around Obs-Exp deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996/97</td>
<td>11,088</td>
<td>774</td>
<td>782</td>
<td>-8</td>
<td>99</td>
<td>106</td>
<td>92</td>
<td>831</td>
</tr>
<tr>
<td>1999/00</td>
<td>11,776</td>
<td>801</td>
<td>754</td>
<td>47</td>
<td>106</td>
<td>114</td>
<td>99</td>
<td>858</td>
</tr>
<tr>
<td>2000/01</td>
<td>11,496</td>
<td>718</td>
<td>670</td>
<td>48</td>
<td>107</td>
<td>115</td>
<td>99</td>
<td>772</td>
</tr>
<tr>
<td>2001/02</td>
<td>12,156</td>
<td>821</td>
<td>736</td>
<td>85</td>
<td>112</td>
<td>119</td>
<td>104</td>
<td>879</td>
</tr>
<tr>
<td>2002/03</td>
<td>12,398</td>
<td>794</td>
<td>674</td>
<td>120</td>
<td>118</td>
<td>126</td>
<td>110</td>
<td>851</td>
</tr>
<tr>
<td>2003/04</td>
<td>12,315</td>
<td>841</td>
<td>668</td>
<td>174</td>
<td>126</td>
<td>135</td>
<td>118</td>
<td>900</td>
</tr>
<tr>
<td>2004/05</td>
<td>13,781</td>
<td>882</td>
<td>766</td>
<td>116</td>
<td>115</td>
<td>123</td>
<td>108</td>
<td>942</td>
</tr>
<tr>
<td>2005/06</td>
<td>14,073</td>
<td>878</td>
<td>707</td>
<td>171</td>
<td>124</td>
<td>133</td>
<td>116</td>
<td>938</td>
</tr>
<tr>
<td>2006/07</td>
<td>16,569</td>
<td>870</td>
<td>683</td>
<td>187</td>
<td>127</td>
<td>136</td>
<td>119</td>
<td>930</td>
</tr>
<tr>
<td>2007/08</td>
<td>16,433</td>
<td>947</td>
<td>813</td>
<td>134</td>
<td>116</td>
<td>124</td>
<td>109</td>
<td>1,009</td>
</tr>
<tr>
<td>1996/7-2007/8</td>
<td>154,674</td>
<td>9,885</td>
<td>8,688</td>
<td>1,197</td>
<td>114</td>
<td>116</td>
<td>112</td>
<td>10,082</td>
</tr>
</tbody>
</table>

Source: Professor Jarman
Why?
A negative culture?

**PRESSURE**
- Targets
- Finance
- FT status
- Jobs

**REACTION**
- Fear
- Low morale
- Isolation
- Disengagement
- No openness

**HABITUATION**
- Tolerance
- Denial
- External reassurance
- Someone else’s problem

**BEHAVIOUR**
- Uncaring
- Unwelcoming
- Bullying
- Keeping head down

©2013 Robert Francis QC
Effect on staff morale of work pressure

I mean in some ways I feel ashamed because I have worked there and I can tell you that I have done my best, and sometimes you go home and you are really upset because you can’t say that you have done anything to help. ... you have answered buzzers, you have provided the medical care but it never seemed to be enough. There was not enough staff ... to provide everything that a patient would need. You ... were just skimming the surface and that is not how I was trained.

A nurse
Patients: fear of trouble

• Some of them were so stroppy that you felt that if you did complain, that they could be spiteful to my Mum or they could ignore her a bit more.

• There would have been a lot of little incidents that just made you feel uncomfortable and made us feel that we didn’t want to approach the staff. I did feel intimidated a lot of the time just by certain ones.

• you have rushed the blood through, I said to the sister, and she said, ... I have had to come in and give the blood and don’t moan... because I have had no break today. That’s what she said, and she probably hadn’t had a break. So I didn’t mention the frusemide to her because she was obviously fraught.

• I think he felt as though he didn’t want to be a nuisance. Because of their attitude in the beginning when he first mentioned about the epidural, he felt as though it was a waste of time of saying that he was in pain.
A junior doctor’s fear

It’s been a big burden to hold... it’s a difficult question to answer, in the sense that I am a relative. However, I must appreciate I am also a doctor and in the eyes of the public I’ll always be a doctor, one would hope. But it’s been very difficult. I have been advised on by many different people, by many different senior doctors, healthcare professionals that I need to be careful. And whether or not that’s paranoia, I’m not sure, but we’re all conscious of our vulnerability as healthcare professionals.

Public Inquiry report page 242; Whitehouse T13.109
Many doctors express fear about the consequences, and this inhibits us from doing what we know to be right. The answer here is not to criminalise that fear, not to introduce an individual statutory duty of candour if you will, but to remember that for speaking up to be meaningful, employers must listen to patients’ and doctors’ concerns.

Extract from speech of Dr Mark Porter to BMA Annual Conference 24 June 2013
Perhaps I should have been more forceful in my statements, but I was getting to the stage where I was less involved and I was heading to retirement ... I did not have a managerial role and therefore I did not see myself as someone who needed to get involved. Perhaps my conscience may have made me raise concerns if I had been in a management role, but I took the path of least resistance. In addition ... most of my patients were day cases and there was less impact on those patients. There were also veiled threats at the time, that I should not rock the boat at my stage in life because, for example, I needed discretionary points or to be put forward for clinical excellence awards.

Evidence given to the Public Inquiry
Surprising though it may seem, surgeons are calmer than physicians. I drew it to their attention and they said: yes, we agree, it is not satisfactory. And because they had no other beds, they had to use that ward, so they said: we have got to go on doing our job because we have patients who need operations; we will have to mend and make do. Which is the Stafford way.

Evidence given to the 1st inquiry

©2013 Robert Francis QC
“You walk away”

The nurses were so under-resourced they were working extra hours, they were desperately moving from place to place to try to give adequate care to patients. If you are in that environment for long enough, what happens is you become immune to the sound of pain. You either become immune to the sound of pain or you walk away. You cannot feel people’s pain, you cannot continue to want to do the best you possibly can when the system says no to you, you can’t do the best you can.
A nurse who spoke up...

Initially only one sister was moved out of the department and then ... the second sister was moved out. And prior to her removal, she was a very close friend of the first sister and she had made it very clear that she was very displeased with me ... and threats were made, both directly and indirectly, friends of hers and the other sisters would make threats to me. People were very often coming up to me ... to, I quote "watch my back", ..."Oh, you shouldn't have done this, you shouldn't have spoken out". And then physical threats were made in terms of people saying that I needed to -- again, watch myself while I was walking to my car at the end of a shift. People saying that they know where I live, and basically threats to sort of my physical safety were made, to the point where I had to at the end of a shift ... at night would have to have either my mum or my dad or my husband come and collect me from work because I was too afraid to walk to my car in the dark on my own.

Evidence at Public Inquiry Day 133.134

©2013 Robert Francis QC
Ambulance driver abuses Mid Staffs Campaigner Julie Bailey on Facebook

“I hope you suffer a life-threatening illness at night where you have to travel further than you should do because your local hospital is closed (your fault).”

“Thank you for closing Stafford hospital, Ha, Ha, Ha, you better now spend more time watching your mother’s grave.”
Isolation? Spot the town...
Isolation through lack of candour

With regards to the content of reports for the Coroner ... as reports are generally read out in full at the Inquest and the press and family will be present, with a view to avoiding further distress to the family and adverse publicity I would wish to avoid stressing possible failures on the part of the Trust ... In my opinion it is self evident from your report that that is probably the case but I feel such a concluding statement may add to the family’s distress and is not one which I would wish to see quoted in the press.

Solicitor’s request to consultant to change report: Public Inquiry Report page 185-186

©2013 Robert Francis QC
How do you change an unhealthy culture
... or protect a healthy one?
Recommendations

- Common values
- Fundamental standards
- Openness, transparency and candour
- Compassionate, caring, committed nursing
- Strong patient centred healthcare leadership
- Accurate, useful and relevant information
- Culture change not dependent on Government

©2013 Robert Francis QC
Openness transparency, candour

• Every healthcare organisation and everyone working for them, or on their behalf, must be **honest, open and truthful in all 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 should be informed** of the incident, given full disclosure of the surrounding circumstances and be offered appropriate support.

• **Full and truthful answers** must given to any question reasonably asked by or for a patient about treatment.

• Any required statement to regulators or commissioners 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**.

*Public Inquiry Report page 1491*
Openness

• Welcome complaints and concerns
• Ban gagging clauses
• Genuinely independent investigation of serious cases
• Involve complainants, staff in investigation
• Real feedback to all
• Real consideration by Trust Board
• Information on actual cases shared with commissioners, regulators, and public
Nurses do not have to wait to be told what to do

• Nurse leadership reinforcing values, standards and delivery
• Recruit for values and compassion
• Training and supervision in humane, skilled and compassionate hands on care
• Support and supervision for HCSWs and other team members
• Report and pursue concerns
Leadership, clarity, commitment

- Supernumerary ward managers [Rec 195]
- Joint doctor/nurse ward rounds
- Named doctor and nurse for each patient on each shift [Rec 199, 228]
- Clear nursing responsibilities for each patient on each shift and effective handover of care
- Constant check on nutrition and hydration [Rec 241]
- **All** team members contribute to care [Rec 227]
- Good communication with patients and supporters [Rec 238]
- Effective supervision of routine observations [Rec 243]
- Rigorous, systemic medication management [Rec 242]
- Responsibility to continue after ward discharge [Rec 229]
ACCURATE USEFUL RELEVANT INFORMATION

• Individual and collective responsibility to devise performance measures [R262-267]
• Patient, public, commissioners and regulators access to effective comparative performance information for all clinical activity
• Improve core information systems
Transparency is coming...

[name]
GMC Number:
Hospital(s):
Special Interests: **Adult Cardiac Surgery, Thoracic Surgery**
Cardiac Surgery Casemix (1st April 2009 - 31st March 2012)

www.scts.org
<table>
<thead>
<tr>
<th>Trust</th>
<th>Name</th>
<th>GMC</th>
<th>AAA</th>
<th>Open</th>
<th>EVAR</th>
<th>Mortality</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basildon and Thurrock University Hospital NHS Foundation Trust</td>
<td>Mr Vijay Gadhvi</td>
<td>4714862</td>
<td>39</td>
<td>14</td>
<td>25</td>
<td>0.0%</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Mr Taleb Jiddy</td>
<td>3473959</td>
<td>14</td>
<td>12</td>
<td>2</td>
<td>0.0%</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Mr Kevin Lafferty</td>
<td>2243494</td>
<td>35</td>
<td>22</td>
<td>13</td>
<td>5.7%</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Mr Jay Menon</td>
<td>4258216</td>
<td>40</td>
<td>26</td>
<td>14</td>
<td>5.0%</td>
<td>▲</td>
</tr>
<tr>
<td>Bedford Hospital NHS Trust</td>
<td>Mr Arindam Chaudhuri</td>
<td>4644592</td>
<td>46</td>
<td>11</td>
<td>35</td>
<td>2.2%</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Mr Tapan Mehta</td>
<td>4781923</td>
<td>20</td>
<td>0</td>
<td>20</td>
<td>0.0%</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Mr Nadim Noor</td>
<td>4004778</td>
<td>35</td>
<td>16</td>
<td>19</td>
<td>0.0%</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Miss Debbie Phillips</td>
<td>3310492</td>
<td>17</td>
<td>10</td>
<td>7</td>
<td>0.0%</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Mr Simon Ray-Chaudhuri</td>
<td>3499344</td>
<td>41</td>
<td>23</td>
<td>18</td>
<td>2.4%</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Mr Paul Tisi</td>
<td>3279612</td>
<td>22</td>
<td>7</td>
<td>15</td>
<td>4.5%</td>
<td>▲</td>
</tr>
</tbody>
</table>
A final thought

88. I am not here for myself. I am here for Gill and the rest of the dead. I am not being sanctimonious, I could walk away at any time but I am not going to. When they took Gill away from me they took away my contentment. I don’t want anyone else to suffer that. Bereavement comes to us all but it is how it comes to you that is important.
Director General Army Medical Services Conference
Doing the Right Thing

Leadership and Culture
Reflections from the Mid Staffordshire Inquiries

25 September 2013

Robert Francis QC
Serjeants’ Inn Chambers
85 Fleet Street
London EC4Y 1AE