Mid Staffordshire scandal highlights NHS cultural crisis

The final inquiry into the care scandal at Mid Staffordshire NHS Foundation Trust has revealed a profound crisis of culture at every level of the health service. David Holmes reports.

It has taken more than 2 years of deliberation, evidence from more than 200 witnesses, and cost over £13 million, but last week the second Francis inquiry finally delivered its damning verdict on why, between 2005 and 2009, hundreds of patients may have died needlessly and countless more suffered appalling violations of their dignity at the Mid Staffordshire NHS Foundation Trust. The inquiry's conclusions, and its no fewer than 290 recommendations for change, now present the National Health Service (NHS) in England with what many regard as the greatest challenge in its history, at a time when it is already going through its largest ever reorganisation.

Since its creation in 1946, the NHS has become an integral part of the UK's national identity. With that in mind, it's hard to overstate the level of incomprehension and incredulity from the public, politicians, and from within the NHS itself, at the sheer depth and breadth of the failings set out in the three volumes of Robert Francis QC's *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*.

The Mid Staffordshire Trust is made up of two hospitals barely 10 miles apart in the town of Stafford, just north of Birmingham in the West Midlands. Stafford Hospital is an acute hospital with what used to be a 24-hour accident and emergency department, while its sister, Cannock Chase Hospital, comprises a minor-injuries unit, rehabilitation facilities, and elderly care services. Between them the two sites share around 450 inpatient beds and about 3000 employees, serving a local population of around 320 000.

The origins of the scandal there date back over a decade. As early as 2001, Francis reveals, the local Primary Care Group (groups which were the predecessors to Primary Care Trusts, and commissioned services from Trusts like Mid Staffordshire) expressed concerns about the management of the Trust. There was a lack of engagement and leadership of clinicians in the Trust, they said, and a report a year later highlighted a "'mis-allocation of resources which could have been directed to specialties experiencing 'enormous pressures', a loss of 'good consultants'", and a lack of management support, inadequate equipment, poor theatre management, an over-reliance on agency staff, and the imposition of waiting list targets at short notice.

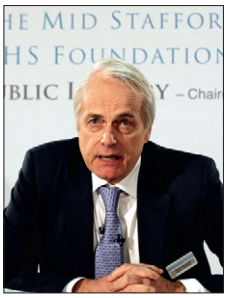
> "'...the system as a whole failed in its most essential duty—to protect patients...'"

Subsequent changes of management at the Trust did nothing to address those early concerns, and the problems mounted. The lid was finally lifted in 2009 when, having been spurred to investigate goings on at the Trust in 2008 by a combination of patients' complaints and abnormally high mortality figures first published in 2007, the now defunct Healthcare Commission (HCC) published a devastating report into the standards of acute care at the Trust. The first Francis inquiry was set up in the aftermath of the HCC report by the then Labour Secretary of State for Health Andy Burnham, primarily to give a voice to those who had been most affected and ensure that their experiences were "fully taken into account in the rebuilding of confidence in the Trust".

What the inquiry heard suggested "failure on a scale that cannot be adequately expressed in statistics". The individual accounts of suffering are too numerous to list here, nor could they be done justice, but they spanned almost every aspect of care and painted an overall picture of a Trust devoid of humanity, totally incapable of recognising patients as people. "The shock that is the appropriate reaction to many of the experiences the Inquiry has been told about", Francis concluded, "reflects the distance between the standard of basic care that is every patient's legitimate expectation and what has, on too many occasions, been delivered at Stafford Hospital."

Having laid bare in forensic detail the true extent of failings at the Trust, the narrow remit of the first inquiry left a number of important questions unanswered. Why, for example, were the plaintiff voices of patients and families unheeded for so long? Why were managers and clinical staff so tolerant of the appalling standards of care? And why, over the course of a decade, did so many warning signs go either undetected or ignored by the regional and national supervisory and regulatory apparatus? In 2010, Andrew Lansley, the Secretary of State for Health of the newly elected Coalition Government, appointed Francis to chair a second inquiry to provide answers to those questions.

The answers are complex and they are many, says Francis, but at their heart is a profound crisis of culture at every level of the NHS. The inquiry found a deep rooted, pernicious cult of management, obsessed with achieving ill-conceived targets yet isolated and wilfully oblivious to day-to-day operational reality, and fixated on image management and cultivating positive publicity while demonstrating little or no interest in acknowledging or addressing problems. Throughout the period considered by the inquiry,



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Robert Francis QC

For the **final report of the Mid Staffordshire public inquiry** see http://www.midstaffspublicinquiry.com/report

For the **HCC report into acute care at the Mid Staffordshire Trust** see http://www.midstaffsinquiry.com/assets/docs/Healthcare%20Commission%20report.pdf

For the **report of the first Francis inquiry into the failings at Mid Staffordshire Trust** see http://www.midstaffspublicinquiry.com/sites/default/files/First_Inquiry_report_volume_1_0.pdf

***Panel*: The cultural revolution (selected recommendations)**

New role for the NHS Constitution
The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations, and obligations of patients.

Regulatory reform
To close regulatory gaps, there should be a single regulator dealing with corporate governance, financial competence, viability, and compliance with patient safety and quality standards for all trusts. Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow.

The role of commissioners
General practitioners need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services.

Openness, transparency, and candour
A statutory obligation should be imposed on all health-care providers to observe a duty of candour. "Gagging clauses" or non-disparagement clauses should be prohibited in the policies and contracts of all health-care organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.

Nursing
There should be an increased focus in nurse training, education, and professional development on the practical requirements of delivering compassionate care. Ward nurse managers should operate in a supervisory capacity, and not be office-bound. They should know about the care plans relating to every patient on his or her ward.

from 2005 to 2008, the executive management of the Mid Staffordshire Trust was blinded to the appalling care given to patients at their hospitals by their excessive focus on securing Foundation Trust status. An oppressive atmosphere in which intimidation and bullying were rife prevented staff from raising concerns, and, when they did, swept them under the carpet.

In parallel, the multiplicity of bodies with regulatory and oversight responsibilities in the NHS seemed to be asleep at the wheel. From health-care systems regulators and performance managers like Monitor, the Care Quality Commission, and the HCC, to professional bodies and regulators like the General Medical Council, the Royal College of Nursing, and the Nursing and Midwifery Council, "all such organisations have the responsibility to detect and redress deficiencies in local management and performance where these occur", says Francis. "It does not need a public inquiry to recognise that this elaborate system failed dramatically in the case of Stafford. As a result, it is clear that not just the Trust's Board but the system as a whole failed in its most essential duty—to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital." Not a single person has yet been held accountable for what happened at the Mid Staffordshire Trust. Yet the systemic failures that the case has brought to light suggest that although atypical, Mid Staffordshire is unlikely to be unique.

The solution to such a cultural crisis, according to Francis, contained within the inquiry's 290 detailed recommendations for change, amounts to nothing short of a cultural revolution. Although dismissing any notion of further reorganisation or restructuring as unhelpful, Francis calls for a re-founding of the current system to re-emphasise "what is truly important" (panel). There should be a strong commitment to common values throughout the system; zero tolerance of noncompliance with fundamental standards of care; the NHS Constitution should be revised to ensure "transparency and candour in all the system's business"; strong leadership in nursing and other professional values; more support and training for those in leadership roles; true accountability; and accessible information to enable performance by individuals, services, and organisations to be compared. "By bringing all this together", Francis writes, "all who work to provide patient care, from porters and cleaners to the Secretary of State, will be working effectively in partnership in a common and positive culture".

In a sign of the enormity of the inquiry's conclusions, the Prime Minister David Cameron, rather than the current Health Secretary Jeremy Hunt, made a statement to Parliament, in which he accepted the inquiry's recommendations. How the recommendations can be implemented, at a time when the NHS is in the throws of its biggest restructure since its inception, is now the burning question.

The London-based King's Fund charity has already done a lot of work on ways of translating some of the more abstract ideas promoted in the Francis inquiry around leadership and cultural change into practice, and Jocelyn Cornwell from the Fund sees the Francis inquiry as an important part of an ongoing debate. "I think it poses a more fundamental challenge not just to the NHS, but health care in modern industrial economies. You look in the [United] States and they have some different issues, but this business of people feeling like once they become a patient they then have to fit in with a system that doesn't really see them as people, that's not unique to the NHS", she says. "Cultural challenge is a huge challenge."

The Fund currently works with 15 clinical teams across 11 acute trusts to help improve patient-centred and family-centred care, and has found that medical leadership is crucial to changing the culture of care. "We help teams examine the experience of their patients and set clear goals to improve them, and we've learnt some important lessons: one of which is the importance of medical leadership", says Cornwell. "Doctors are still very powerful within the system, even though they might not always feel it, but they generally think in terms of clinical quality, and not in the round about the experience of their patients. In our teams where the consultants fully engage we see huge change happening very quickly." For the NHS, that change can't come quickly enough.

David Holmes

Robert Francis QC

Press Statement

Today I publish the report of this Inquiry following my consideration of the evidence of over 250 witnesses and over a million pages of documentary material. It builds on my earlier report, published in February 2010 after the earlier independent inquiry on the failings in the Mid Staffordshire NHS Foundation Trust between 2005 and 2009. I recommend that those seeking a full understanding of all the issues read both reports.

This is a story of appalling and unnecessary suffering of hundreds of people. They were failed by a system which ignored the warning signs and put corporate self interest and cost control ahead of patients and their safety. I have today made 290 recommendations designed to change this culture and make sure that patients come first.

We need a patient centred culture, no tolerance of non compliance with fundamental standards, openness and transparency, candour to patients, strong cultural leadership and caring, compassionate nursing, and useful and accurate information about services.

The evidence at both inquiries disclosed that patients were let down by the Mid Staffordshire NHS Foundation Trust. There was a lack of care, compassion, humanity and leadership. The most basic standards of care were not observed, and fundamental rights to dignity were not respected. Elderly and vulnerable patients were left unwashed, unfed and without fluids. They were deprived of dignity and respect. Some patients had to relieve themselves in their beds when they offered no help to get to the bathroom. Some were left in excrement stained sheets and beds. They had to endure filthy conditions in their wards. There were incidents of callous treatment by ward staff. Patients who could not eat or drink without help did not receive it. Medicines were prescribed but not given. The accident and emergency department as well as some wards had insufficient staff to deliver safe and effective care. Patients were discharged without proper regard for their welfare.

The many experiences like this were truly shocking to hear. Many will find it difficult to believe that all this could occur in an NHS hospital. I want to pay tribute to the many patients and those close to them who bravely and with

great dignity gave evidence to me at the two inquiries. It is their efforts which have brought these shocking facts to light. It is important for them, and all others who have suffered as they have that the necessary changes are made to protect patients and to provide the proper and fundamental standards of care to which we are all entitled.

What brought about this awful state of affairs? The Trust Board was weak. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. It did not tackle the tolerance of poor standards and the disengagement of senior clinical staff from managerial and leadership responsibilities. These failures were in part due to a focus on reaching targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable standards of care.

The purpose of this inquiry was to work out why these problems many of which should have been evident over a period of years, were not discovered earlier. Regrettably there was a failure of the NHS system at every level to detect and take the action patients and the public were entitled to expect.

- The patient voice was not heard or listened to, either by the Trust Board or local organisations which were meant to represent their interests. Complaints were made but often nothing effective was done about them.

- The local medical community did not raise concerns until it was too late.

- Local scrutiny groups were not equipped to understand or represent patient concerns or to challenge reassuring statements issued by the Trust.

- The Primary Care Trusts which were under a duty to arrange for the provision of safe and effective care were not set up for and did not effectively ensure the quality of the health services they were buying; they did not have the tools to do the job properly

- The Strategic Health Authority was the regional representatives of the NHS and the Department of Health. It did not put patient safety and wellbeing at the forefront of its work. It defended trusts rather than holding them to account on behalf of patients. It was uncritical in its support of Foundation trust status for the Trust. It preferred to explain

away concerns such as those about high mortality rates rather than root out matters which would concern any patient.

- Monitor's duty was to ensure that trusts were fit to be granted the independence of Foundation Trust status. It focussed on corporate governance and financial control without properly considering whether there were issues of patient safety and poor care.

- The Department of Health did not ensure that ministers were given the full picture when advising that the Trust's application for Foundation Trust status should be supported. It was remote from the reality of the service at the front line.

- The Healthcare Commission was required to assess trusts against standards which did not adequately test the quality of care being provided to patients, but it was its painstaking investigation by a team of skilled inspectors that eventually brought the truth to light. Even then there was a reluctance by those who had the power to do so to intervene urgently to protect patients.

- Other organisations, including healthcare professional regulators, training and professional representative organisations failed to uncover the lack of professionalism and take action to protect patients.

At every level there was a failure to communicate known concerns adequately to others, and to take sufficient action to protect patients' safety and wellbeing from the risks arising from those concerns. In short the trust that the public should be able to place in the NHS was betrayed.

What caused such a widespread failure of the system? This is not something which can be blamed simplistically on one policy or another, or on failings on the part of one or even a group of individuals. There was an institutional culture in which the business of the system was put ahead of the priority that should have been given to the protection of patients and the maintenance of public trust in the service. It was a culture which too often did not consider properly the impact on patients of actions being taken, and the implications for patients of concerns that were raised. It was a culture which trumpeted successes and said little about failings. Standards and methods of ensuring compliance were not focussed on the effect of service deficiencies on patients There was a tolerance of poor standards and the consequent risk to patients. Agencies frequently failed to share their knowledge with each other.

Assumptions were continually made that important functions were being performed satisfactorily by others. The dangers of the loss of corporate memory from major reorganisations were inadequately addressed and during the reorganisation of PCTs and SHAs there was a loss of focus upon the care patients received.

The NHS is full of dedicated, skilled people committed to providing the best possible care to their patients. There is much to be proud of about what they do for us. However the service so valued in this country and respected internationally is in danger of losing public trust unless all who work in it take personal and collective responsibility to root out poor practice wherever it is to be found.

What do we need?

Conventionally, some might say depressingly, when a disaster has occurred in the NHS the usual approach has been to blame and sack individuals or to propose major reorganisations. What has been found to be wrong here cannot be cured by finding scapegoats, and/ or recommending major reorganisations yet again

What is required now is a real change in culture, a refocusing and recommitment of all who work in the NHS – from top to bottom of the system - on putting the patient first. We need a common patient centred culture which produces at the very least the fundamental standards of care to which we are all entitled, at the same time as celebrating and supporting the provision of excellence in healthcare.

We need common values, shared by all, putting patients and their safety first; we need, a commitment by all to serve and protect patients and to support each other in that endeavour, and to make sure that the many committed and caring professionals in the NHS are empowered to root out any poor practice around them. These values need to be the principal message of the NHS constitution, to which all staff must commit themselves.

How is this to be done?

The NHS is a complex and frequently re-organised system trying to maintain its service against a backdrop of increasing demands and challenging financial expectations. The last thing required is a set of proposals from me requiring more radical reorganisation. So my recommendations are intended above all to support all in the service to make patient centred values and

standards real, but also to bring teeth to the task of changing behaviours where required. Essentially I think five things are needed:

- First, a structure of clearly understood fundamental standards and measures of compliance, accepted and embraced by the public and healthcare professionals, with rigorous and clear means of enforcement: we need a list of standards, about patient safety, the effectiveness of treatment, and basic care - the requirements we will all agree should be in place to permit any hospital service to continue. These standards should be defined by what patients and the public want and are entitled to, and what healthcare professionals agree can be delivered. Non compliance with these fundamental standards cannot be tolerated. Any organisation unable consistently to comply should be prevented from continuing a service which exposes patients to risk. To cause death or serious harm to a patient by non-compliance with fundamental standards should be a criminal offence. Standard procedures, guidance and assessment tools designed to enable organisations and individuals to comply with fundamental standards in different clinical settings should be produced by the National Institute of Clinical Excellence (NICE), with the help of relevant professional and patient organisations. These should include guidance on staffing. Individuals should be supported to report non compliance or matters which might prevent compliance to their organisations. They should be protected when they do this.

  Fundamental standards must be policed by the Care Quality Commission. It is this inquiry's firm conclusion that physical inspection by well qualified, trained and experienced hospital inspectors is the most effective means of monitoring compliance with standards in hospitals. Regulation would also be more effective if compliance with fundamental standards and requirements for clinical and corporate governance and finance control, were regulated by one organisation. The CQC should regulate all these matters together rather than responsibility being divided between CQC and Monitor. The CQC would also be expected to intervene where necessary to protect patients from non-compliance with the fundamental standards.

In all walks of life the buyer wants to ensure that he gets what he pays for. Health should be no different. Therefore commissioners of healthcare services must be required to develop and require compliance with other standards – which I have called enhanced quality standards - of quality, effectiveness and other requirements over and above the fundamental standards. As the buyer of these services on our behalf commissioners must ensure that these enhanced standards are delivered by their providers. In this way the role of the regulator and commissioners responsibility would be simplified and clarified.

- Secondly, openness, transparency and candour throughout the system: A common culture of serving and protecting patients and of rooting out poor practice will not spread throughout the system without insisting on openness, transparency and candour everywhere in it. A duty of candour should be imposed and underpinned by Statute and the deliberate obstruction of this duty should be made a criminal offence.
    - Openness means enabling concerns and complaints to be raised freely and fearlessly, and questions to be answered fully and truthfully;
    - Transparency means making accurate and useful information about performance and outcomes available to staff, patients, the public and regulators.
    - Candour means informing any patient who has or may have been avoidably harmed by a healthcare service of that fact and a remedy offered where appropriate, regardless of whether a complaint has been made or a question asked about it.

Every provider trust must be under an obligation to tell the truth to any patient who has or may have been harmed by their care. It is not in my view sufficient to support this need by a contractual duty in commissioning arrangements. It requires a duty to patients, recognised in statute, to be truthful to them. It requires staff to be obliged by statute to make their employers aware of incidents in which harm has or may have been caused to patients so they can take the necessary action. The deliberate obstruction of the performance of these duties and the deliberate deception of patients in this regard should be criminal offences. So called “gagging clauses” which might prevent a concerned employee or ex employee raising honestly held concerns

about patient safety should be banned. Trusts must be open and honest with regulators. It should be an offence deliberately to give them misleading information. Information provided to the public about performance should be required to be balanced, truthful and not misleading by omission. Quality accounts should be independently audited. The CQC should be responsible for policing these obligations.

- Thirdly, improved support for compassionate caring and committed nursing: proper standards of nursing care lie at the heart of what is required to protect patients when in hospital. The majority of nurses are compassionate, caring and committed. They should be given effective support and recognition, and be empowered to use these qualities to maintain standards. Entrants to the profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of their patients. Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard and their training must incorporate the need to experience hands-on patient care. Named clinicians should be responsible for the welfare and care of each patient in hospital.

  Healthcare support workers are a highly important but insufficiently valued part of the workforce: they provide most of the hands on care for elderly and vulnerable patients. They need the help of consistent training, and standards of performance. Patients are not currently adequately protected from those who are unfit to do this work. The time has come in for healthcare support workers to be regulated by a registration scheme enabling those who should not be entrusted with the care of patients to be prevented from being employed to do so. This needs to be supported by common training standards and a code of conduct. No-one should have hands-on care of patients unless properly trained and registered. Patients and the public are entitled to greater clarity about the status of those who provide direct physical care to them.

  Nursing needs a stronger voice. This can be achieved by strengthening nursing representation in organisational leadership, enhancing the links with their professional regulators, better appraisal, and encouraging strong nursing leadership at ward level. I would like to see more recognition of the extremely important role nursing plays in the care of

older patients by the creation of a new registered status as a registered older person's nurse. I would like their profession to consider how greater authority can be brought to their representative voice.

- Fourthly strong and patient centred healthcare leadership: leadership generally in the NHS is under challenge and needs more effective support. The necessary culture will only flourish if leaders reinforce it every day in every part of the service. A NHS leadership staff college could be created, offering all potential and current leaders the chance to share in a form of common training designed to equip them to exemplify and implement the common culture. They should be supported by a common code of ethics and conduct for all leaders and senior managers.

  The public are entitled to expect leaders to be held to account effectively when they have not applied the core values of the Constitution, or are otherwise shown to be unfit for the role. Currently leaders who are registered as doctors or nurses can be disciplined by a regulator for failing to protect patients. Other leaders cannot. A more level playing field would enhance leadership teamwork and increase the public's confidence in the NHS. It should be possible to disqualify those guilty of serious breach of the code of conduct or otherwise found unfit from eligibility for leadership posts. This will require a registration scheme and a requirement that only fit and proper persons are eligible to be directors of NHS organisations. While this regulatory function could be performed by an existing regulator, the need for a separate entity for this purpose should be kept under review.

- Finally, accurate, useful and relevant information: information is the lifeblood of an open transparent and candid culture. All professionals, individually and collectively, should be obliged to take part in the development, use and publication of more sophisticated measurements of the effectiveness of what they do, and of their compliance with fundamental standards. Patients, the public, employers, commissioners and regulators need access to accurate, comparable and timely information. Improvements are needed in the core information systems for the collection of data about patients, both to support their individual treatment and the accurate collation of information for statistical purposes. Difficulties in achieving this are no

excuse for inaction. The Information Centre for Health and Social Care has an important role to play in this field. Boards must be accountable for the presentation to the public of balanced and candid information about their trusts' compliance with fundamental standards. It should be a criminal offence to be a party to a wilful or reckless false statement as to compliance with safety or fundamental standards.

Many of my recommendations will require development in detail to be implemented. The suffering undergone by patients and those close to them in Stafford demands that the lessons to be learned are not considered for a day or two and then forgotten. Government and the Department of Health have an important role to play in changing the culture, but this does not mean everyone else in the system can sit back and wait to be told what to do. Every single person and organisation within the NHS, and not only those whose actions are described in this report, need to reflect from today on what needs to be done differently in future. All have a responsibility to consider what is exposed by my two inquiries, and to consider how to apply the lessons themselves, individually and collectively. I have recommended that every organisation should report publically on a regular basis on whether they have accepted my recommendations and what they are doing to implement them, and that the House of Commons Health Select Committee should be invited to review regularly the progress being made by organisations which are accountable to Parliament.

My recommendations represent not the end but the beginning of a journey towards a healthier culture in the NHS in which good practice in one place is not considered to be a reason for ignoring poor practice somewhere else; where personal responsibility is not thought to be satisfied by a belief that someone else is taking care of it; where protecting and serving patients is the conscious purpose of everything everyone thinks about day in day out. Patients are entitled to be the first and foremost consideration of the system and all those who work in it. I very much hope that this report and its recommendations will help to bring this about.

6 February 2013