Mid Staffordshire – some reflections for clinicians

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Robert Francis QC outlines the findings of the various investigations into the care provided by the Mid Staffordshire NHS Foundation Trust, discussing how the healthcare professions can contribute to implementing the recommendations made to protect patient safety in the future.

Figure 1. The Healthcare Commission's investigation raised serious concerns about the accident and emergency service, including inadequate staffing levels (©Gustoimages/Science Photo Library)

The Healthcare Commission's investigation into the care provided by the Mid Staffordshire NHS Foundation Trust was triggered by rising concerns about the mortality rates, in part from the results of the Hospital Standardised Mortality Ratio (HSMR), but more particularly from its own mortality alert system. The investigation was searching and lengthy. The eventual report, published in March 2009,[1] contained a series of very serious findings and criticisms. Among the Healthcare Commission's findings were:

- a less than 5 per cent chance that the Trust's outlying position in the HSMR was due to chance
- a long history of poor information governance
- serious concerns about the accident and emergency (A&E) service, including a lack of protocols for emergencies, inadequate clinical and nursing staffing levels and equipment, weak leadership and training, supervision of junior doctors, undue pressure to meet targets, performance and recording of observations (Figure 1)
- understaffed and poorly managed medical wards, caused by a reconfiguration
- unacceptable care for patients on medical wards, including lack of help for feeding, drinking and toileting, unacceptable delays in answering calls for help, lack of cleanliness with regard to beds, wards, and patients themselves
- absence of co-operative working practices in surgery practitioners, including inappropriate management of theatre lists, leading to patients suffering unacceptable care, and postoperative signs of deterioration were missed.

Some striking facts leading to these findings are summarised in Box 1.

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INDEPENDENT INQUIRIES

This investigation caused considerable public and political concern, as a result of which two reviews were commissioned into the failings in A&E and commissioning issues.[2,3] The level of concern did not diminish and an independent inquiry into the care and treatment provided by the Trust was commissioned by the Government in July 2009. The intention was to give a voice to patients and their families, and to Trust staff. The experiences of more than 900 people were collected. The resulting report set out many disturbing stories (Box 2).[4]

BOX 1. Background to the Healthcare Commission's findings

- Triage in A&E by unqualified receptionists
- Little teamwork among surgeons
- Inadequate mortality reviews
- Poor governance and lack of Board awareness of the extent or severity of the complaints made by patients
- Known staffing issues left unaddressed
- Mortality issues dismissed as being the result of problems with the data

A recommendation for yet a further inquiry into the actions of the surrounding system in relation to this Trust was accepted by both the Labour Government and its successor Coalition Government. A statutory inquiry was ordered under the Inquiries Act 2006 with powers to compel the attendance of witnesses and the production of documents. The report of this inquiry was published in February 2013.[5]

It found that, in addition to serious failings within the Trust from the front line to the Board, the commissioning oversight, regulatory and policy mechanisms had failed to put the patient first at all times or to give sufficient priority to patient safety and quality of care over system-led targets and focus on finance. There was evidence throughout the system of a culture that was not conducive to ensuring patient safety and quality of care and which had allowed the appalling standards of care in Stafford to continue for so long. The suspicion that Stafford was not alone in this has since been reinforced by the reports of the Care Quality Commission (CQC) on dignity and nutrition, and the Keogh review.[6]

Report findings

These reports make uncomfortable reading for medical and nursing practitioners of all levels of seniority. Among the events considered in the report:

- surgeons were said to have refused to agree common protocols with each other, leaving theatre staff uncertain what procedures to adopt
- consultants did not persist in pursuing their concerns about the effect on patients of ward reconfiguration
- an experienced senior trainee in A&E received no constructive response when he raised justifiable issues with his educational supervisor, his senior consultant, and at a meeting at his College
- the Royal College of Surgeons' review of the surgical division concluded that the department was dysfunctional and suffered from weak leadership. Recommendations to the Trust were not followed up, and the reported concerns were not shared with a regulator. A repeat of the review two years later identified worse problems, and the surgical division was now described as dangerous
- an internal investigation into a patient's death warned of serious systemic failings and the risk of recurrence was not followed up
- after an initial protest, a senior consultant complied with a request by the Trust's in-house lawyer to remove criticisms of the care provided to a patient from a report intended for the coroner
- a whistleblowing nurse in the A&E department was not protected from harassment by colleagues of the staff whose conduct she had reported, to the extent that she did not feel safe to leave work at night unaccompanied
- a shortage of nursing staff and inadequate skill mix was identified, but remedial action took far too long. In the meantime, little consideration appears to have been given to the patient safety implications
- a reluctance to engage with or in management was widespread among professional staff
- clinical audit and other governance measures were at best approached reluctantly by many
- above all, so many examples of appalling nursing care and attention could not have occurred if medical staff and senior nurses had looked out for and corrected the deficiencies that were so obvious to patients and those close to them.

EXPLANATIONS FOR FAILURE

A number of explanations for this failure to offer patients real protection emerged, including self-interest, fear, isolation, tolerance of poor standards, disengagement from management and lack of leadership.

BOX 2. Report from a patient's relative[4]

'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 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.

I was horrified and went and got somebody and two nurses came... stripped her and washed her and cleaned her up and made her comfortable. But I mean, how long she would have been left if we had not arrived, I don't know.

Everyone could have seen her. That is why I was so distressed because my mum would have been horrified if she had known that people were walking past and could see her. The door was just left open all the time. I mean, that doesn't bother me, the door open, if they can see what is going on then, but to just keep bypassing her, and so many people must have walked past and seen her; why didn't somebody go in to her?'

Self-interest
There was evidence suggesting some clinicians were afraid to raise concerns because of potential adverse consequences for their careers or remuneration (Box 3).

Fear
Staff would have been afraid of raising concerns because of the anticipated reaction of colleagues. That fear was rationally based, as can be seen from the harassment of a whistleblowing nurse (Box 4). Patients hesitated to complain because of the fear of retribution from the staff caring for them (Box 5).

Fear is a powerful inhibitor against raising legitimate concerns, even where it is misplaced. Professionals need to ensure they behave in such a way that patients and their colleagues can be confident no retribution will follow the raising of a concern.

Isolation
There was little evidence that clinicians in some disciplines participated in or took advantage of peer networks.

Tolerance of poor standards
A working environment can become so stressful or understaffed and under-resourced that staff feel compelled to accept poor standards and over time will become inured to the consequences for patients (Box 6).

Disengagement from management
There was evidence of a notable reluctance on the part of doctors to come forward for the role of medical director, or to engage with management over issues causing concern, attributable in part to the lack of response when issues were raised.

Lack of leadership
An example of this was the passivity with which the first report from the Royal College of Surgeons was received. Although its recommendations were felt to be inadequate to address a difficult professional problem, very little effective action seems to have been taken to resolve it in the interests of patients.

BOX 3. Clinician's evidence at the public inquiry

'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.'

RECOMMENDATIONS
Several recommendations have been made to address these professional cultural issues. It is not necessary for any professional, individually or collectively, to wait for the Government response to take the necessary action. These include:

- commitment to the core values in the NHS Constitution
- participation in and development of common working procedures
- participation in the development of publishable individual and collective performance measures
- reinforcement of responsibility for patients by identification on each shift of a doctor and a nurse responsible for each patient
- participation in better communication with patients and those who care for them
- recruitment and training, taking account of the service's common values
- participation in leadership training and development, preferably through a staff college
- a system of accountability applied to all in leadership roles, whether or not they are clinicians
- co-operation with employers and colleagues in fulfilling obligations of candour towards patients
- preventing training in services that are not safe for patients; trainees should be protected from adverse consequences from raising concerns
- participation in training supervision and monitoring, peer review and regulatory inspection.

PROFESSIONAL CULTURAL CHANGES
Since the publication of the public inquiry report, time has rightly been taken to consider how to implement many of its recommendations, but much has already happened to suggest a collective determination to make the necessary changes in culture.

At the highest level there has been public acknowledgment that there is an unacceptable level of mediocrity in the health service.[7]

BOX 4. Nurse's evidence at the public inquiry

'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 my physical safety were made, to the point where I 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.'

BOX 5. Evidence from patients' families

- **'Some of them were so stroppy that you felt that if you did complain, 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'**
- **'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'**

The need for a statutory organisational duty of candour to patients has been accepted. This will require the co-operation of medical and nursing professionals, whether or not a similar individual statutory duty is introduced.

A paediatric cardiac surgical service was temporarily suspended while the risk to patient safety implied by mortality data was explored, rather than continuing while working out if the figures were reliable.[8] This represents a sea change in the significance given to patient safety risks.

The NHS medical director was instructed to review performance and safety at 14 provider trusts that were outliers on mortality measures. The subsequent report has disclosed to the public serious concerns about standards of service.

Individual performance data for vascular surgeons has been published with the consent of the vast majority of relevant consultants.[9]

The CQC is proposing the introduction of expert-led hospital inspections in which clinicians will play a leading role. It has evidenced an intention to be more open by retaining a whistleblowing commissioner on its board, publishing a report critical of its own performance.[10-12]

CONCLUSION

While much of the care provided by the NHS is of a high standard, delivered by staff committed to putting the patient first, and striving at all times for improvements, the findings about Mid Staffordshire have confirmed the existence within the NHS of an unacceptable culture in many parts of the service militating against consistently safe and effective care. A strong and patient-centred professional leadership, commitment to teamwork, and to openness, transparency and candour towards patients and the public is needed. This requires a visible and sustained commitment on the part of all medical and clinical staff to re-assert their professionalism. While this task will be much easier if there is a wholehearted contribution to it from all leadership in the system as a whole, much can be achieved by healthcare professionals who insist on working by the values that brought them to this invaluable work in the first place.

BOX 6. Evidence from a senior medical trainee in A&E

'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.'

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