RETURN TO THE KILLING FIELDS

A chronicle of deaths foretold

SIR DAVID NICHOLSON, the NHS chief executive who refuses to resign, once joked that Andrew Lansley's disastrous NHS reforms were "so big, you can see them from space". On that basis, the Mid Staffs scandal is so rotten you can *smell* it from space.

When the Bristol heart scandal whistleblower Dr Steve Bolsin was asked in 1998 how to avoid future disasters in the NHS, he said simply: "Never lose sight of the patient." Thirty-five babies died in Bristol due to substandard care over a four-year period, and the unit was dubbed "The Killing Fields" by staff (as revealed in *Eye* 793). A decade and a half later, Robert Francis QC has found that 1,197 people died at Mid Staffordshire hospital between 1996 and 2008, 492 of those deaths happening between 2005 and 2008. How could the NHS, with record funding, published death rates and armies of regulators lose sight of so many patients, some of whom died in appalling conditions? And who is responsible? Francis provided detailed answers to the first question and completely ducked the second.

In avoiding any direct criticism of named policies, politicians or senior NHS managers who oversaw this lengthy disaster, Francis has put another nail in the coffin of accountability in the NHS. The fact that no one in the Department of Health saw the need to accept responsibility and resign over Mid Staffs shows a staggering lack of insight.

Most hospital chief executives the *Eye* has spoken to think Nicholson should resign; but all are too frightened or simply "not allowed" to say so publicly, such is the culture of fear in the NHS. There are plenty of brilliant managers who would do a far better job than Nicholson, but they won't get a chance. Nicholson, remember, was the interim chief executive of the health authority overseeing Stafford Hospital in August 2005 and, later that year, sat on the panel that appointed the cost-cutting chief executive Martin Yeates. Nicholson then strolled into his next job as chief executive of the NHS Commissioning Board unopposed.

GOING NOWHERE: Sir David Nicholson (below), the NHS boss who refuses to budge; and Robert Francis (right), the inquiry chairman whose report found… no one to blame

The sense of relief among politicians on both sides at the "no one at the top to blame" line was palpable. David Cameron dished out platitudes and called on the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) to strike off incompetent or callous frontline staff – but any competent regulator would have done so already. Health secretary Jeremy Hunt says he wants police to investigate the hospital; but the NHS generals whom both Labour and the coalition have shared, are sitting pretty. What smells like corporate manslaughter gets washed away, as far from Whitehall as possible.

Ignoring Francis already

Francis was commendably insistent that the legally-enforced gagging of whistleblowers must end (see *Shoot the Messenger*, *Eye* 1292) – a practice Commons health select committee chairman Stephen Dorrell accepts is "corrupt". But the NHS is at it again.

On 14 February Gary Walker, the former CEO of United Lincolnshire hospital (one of 14 trusts being belatedly investigated for persistently high death rates), bravely broke his gag to tell Radio 4's *Today* programme how he had been bullied, sacked and silenced for saying how targets for non-emergency patients were endangering emergency admissions.

His story implicates both Nicholson (to whom Walker had written, warning him of the dangers) and his managing director of commissioning, Barbara Hakin OBE, who was CEO of East Midlands SHA. The BBC put the allegations to the Department of Health, and within hours a letter from the trust's lawyers threatened Walker with the loss of all his pay-off if he didn't shut up.

Last June the *Eye* referred Dr Hakin to the GMC for failing to protect either Walker or his patients, and the GMC is investigating at the customary speed of a glacier. Dorrell, as select committee chair, told *Today*'s John Humphrys that he had been "in correspondence" with Walker for two years. Walker claims Dorrell never replied to his letter and *must* now be called in front of the committee to hear his evidence against Hakin and Nicholson. The committee must also ascertain if anyone at the DoH tipped off the trust or its lawyers, Beachcroft, who issued the sinister and threatening letter to Walker.

Knighthood for a whitewash?

One wonders what version of his report Robert Francis was reading at the press conference on 6 February. He looked like a man held hostage. The interminable delay in publication to allow for rewrites had reportedly been because those he was minded to criticise had launched vigorous legal defences. In the end he opted for a ridiculous "no scapegoats, blame the system" approach. This was endlessly debated after the Bristol Inquiry report in 2001, when a culture of "fair blame" was proposed. Ill thought-out, untested, rushed and brutally-enforced reforms undoubtedly contribute to NHS disasters, but individuals also have to be held accountable for their actions. Patients and staff trust a system that is just. But the judge delivered no justice.

Had Francis had the time to wade through the Bristol Inquiry evidence, he would have found where to place overall responsibility. On 9 February 2000, Rohan Pirani, lead counsel for the Department of Health, delivered an unequivocally clear statement of accountability: *"If I may move on, sir, to the area of responsibility and accountability, and make it absolutely clear again that the Department of Health accepts that it is responsible and is accountable for any failings of the systems that were in place during the period covered by the Inquiry. Ultimate responsibility rests with the Department of Health and the secretary of state."*

On 1 April this year, the Health and Social Care Act will destroy whatever lines of accountability exist in the NHS. The secretary of state will be off the hook completely; the NHS Commissioning Board becomes a bank with no responsibility for the delivery of healthcare; and no one knows what the Department of Health will do. Foundation trusts will have even more independence and power to bury bad news, while clinical commissioning groups and regulators are unlikely to have the clout to uncover it. The patient voice, in the form of "Healthwatch", will be as weak as ever. The Francis Inquiry was a final chance to make the NHS accountable to patients and it has failed.

Lest we forget

If you only have time to read one Francis report, make it his first independent inquiry, published in February 2010. The stories behind the harm are staggering. An old man forced to stay on a commode for 55 minutes wearing only a pyjama top; a woman whose legs were "red raw" because of the effect of her uncleaned faeces; piles of soiled sheets and vomit bowls left at the end of beds, a woman arrived at 10am to find her 96-year-old mother-in-law "completely naked… and covered with faeces… It was in her hair, her nails, her hands and on all the cot sides… it was literally everywhere and it was dried." Another woman who found her mother with faeces under her nails asked for them to be cut, but was told that it was "not in the nurses' remit to cut patients' nails".

The care was so bad that as many as 1,200 people died unnecessarily, often in appalling conditions. The poor care was known about for years and flagged up by successive mortality data alerts. The problem was that no one acted on the data or listened to the patients and relatives. And whistleblowers

were threatened and silenced. Whoever oversaw such a climate of fear in the NHS has to go.

Nicholson refuses to budge

David Nicholson has been chief executive of the NHS since 2006, and of the strategic health authority that sheltered Mid Staffs beforehand. Having sat on the appointment panel that decided Martin Yeates would be a good CEO, his fingerprints are all over Mid Staffs. But despite being the accountable officer for the NHS, Francis decided he wasn't accountable.

Nicholson's statement to the most recent public inquiry said: "The point at which I became aware of the severity of the Healthcare Commission's concerns about patient care at [Mid Staffs] was shortly after Sir Ian Kennedy met with Alan Johnson [*former Labour health secretary*] on 4 February 2009." And yet Francis heard evidence that in May 2008, representatives from the Healthcare Commission, including Sir Ian Kennedy, had met Nicholson and described "an overwhelming response from local people on the questions of quality of care" at Mid Staffs, particularly from Cure the NHS. Nicholson cautioned them that they should "remain alive to something which was simply lobbying… as opposed to widespread concern." Nicholson does not recall saying this.

He told the inquiry: "The board of Mid Staffordshire failed in its statutory duties to provide good quality care and managing within the resources provided. That no other hospital failed so profoundly and persistently in this period, serves to emphasise the singular rather than the systemic nature of this case." The inquiry counsel's closing submission said: "There are highly likely to be other examples within the health service of poor management, poor governance and poor care and it is the system's duty to uncover them. This approach is supported by the many letters which the inquiry has received from all over the UK about failures of care in other trusts… with respect to him [Nicholson], this seems to us to be a very dangerous attitude to take."

The fact that 14 other hospitals that have had high death rates for years but are only now being investigated shows how much bigger the problem is than Mid Staffs. The DoH has belatedly realised that avoidable death is a bad thing.

Nicholson accepted in his evidence that the NHS had been too focused on finance: *"Quality was not the organising principle of the NHS, it wasn't the thing that was driving us during that period."* Had the Department of Health and Labour government noted the recommendations of the Bristol Inquiry, it certainly would have been.

From Bristol to Mid Staffs and back

Bristol and Mid Staffs have similarities, in that the problems dated back a decade before any action was taken to protect patients, despite many levels of the NHS being aware of the poor care and high death rates, or at least having access to a sea of data that pointed to a serious problem, if only they'd been bothered to look.

In both, the scandals would have remained buried had it not been for a highly organised, determined and ethical group of relatives who simply would not go away until they got a public inquiry. As with Bristol, the biggest danger to patients in the NHS would be to dismiss it as an isolated incident in one hospital. Appalling care still occurs in pockets across the NHS, but in the absence of effective regulators, it usually only comes to light if patients, relatives or whistleblowers make an extraordinary effort to expose it.

In Bristol, whistleblower Steve Bolsin was prepared to sacrifice his career by taking his concerns outside the hospital when its managers refused to act. Despite legislation designed to protect whistleblowers following Bristol, such action remains a career death wish in the NHS. The few staff who tried to blow the whistle on Mid Staffs were bullied, threatened and in one case suspended, in an attempt to keep the scandal "in house".

That attempt was futile because the appalling care was so obvious to patients and relatives. In Bristol, no one doubted that the surgeons were trying their best, but their best was simply not good enough and they lacked the insight to stop when there was clear evidence that too many babies were dying.

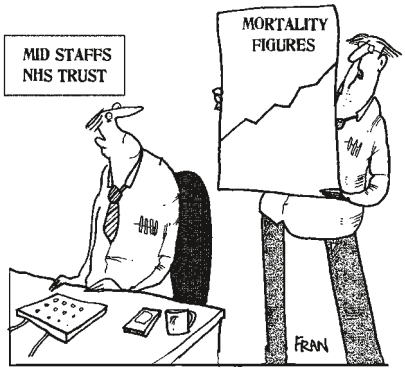
At Mid Staffs, some staff still managed to deliver compassionate care in the most stressful circumstances; many became terse and uncaring when their working conditions were terrible; and a few simply shouldn't have been working in the NHS. Unnecessary deaths did not just occur in a war zone emergency department or because of callous neglect of the elderly, but across all age ranges and in many specialties, including surgery, some of which was "grossly negligent", according to the Royal College of Surgeons.

Mid Staffs is currently one of many bust trusts, struggling on government handouts and shutting its emergency department overnight to save money and lives. It was always too small to be viable as a foundation trust; and the disastrous decision to push it down that route contributed to staff cut-backs that made the hospital so dangerous, and bred a culture of denial, demotivation and desensitisation. Twenty-one years after the *Eye* broke the story of the Bristol scandal, child heart surgery still hasn't been safely reorganised into fewer, better resourced units. Bristol is in trouble again, with further allegations of avoidable deaths, harm and understaffing in its child heart surgery unit.

Asleep at the wheel or wilfully blind?

After the Bristol Inquiry, campaigners tried to pursue a charge of corporate manslaughter against the NHS, a charge that requires "a controlling mind" being wilfully blind to the suffering, rather than just asleep at the wheel. The politicians were clearly asleep – none more so than Andy Burnham (pictured above), Labour health secretary from June 2009 and now a shadow of his former self. But in June 2007, as minister of state for delivery and reform at the Department of Health, he announced: *"I am delighted that Mid Staffordshire general hospitals NHS trust has now reached a high enough standard to be considered as an NHS foundation trust… I would like to congratulate all of the staff of the trust on this achievement."*

This statement was about as inaccurate, falsely reassuring and incompetent as it's possible to be. Francis found that Burnham's



"Which way up do you want it?"

understanding of how the system for gauging NHS trusts' suitability for foundation status operated "differed from the reality". His "belief that it identified trusts which were 'high performing' was at odds with the fact that there was little, if any, focus on an assessment of an applicant's current ability to deliver services compliant with standards."

Burnham backed Mid Staffs' application for foundation status in 2007 after seeing a four-line summary from his civil servants. But the high death rates (127) at Mid Staffs for that year were openly published online and in the *Daily Telegraph*. The DoH and Burnham claim they were completely unaware of them. Unbelievable.

The importance of death

In 2001, the Kennedy Inquiry into Bristol had made 198 recommendations about safe and humane healthcare that could have been cut and pasted into the Francis report, leaving him just another 92 to come up with. Sir Ian observed: "There was no systematic mechanism for monitoring the clinical performance of healthcare professionals or of hospitals." And until there was, there was no chance of identifying, or acting quickly on, other disasters in the NHS.

Death is only one measure of the quality of healthcare, but it's a crucially important one. It's relatively easy to spot, one-off, irreversible and – when avoidable – it's the biggest harm the NHS can do to you. It also must be registered by law, so it's harder to hide in the chaos of inaccurate, incomplete and "missing" handwritten NHS records.

It was a comparison of death rates in different units that revealed the Bristol heart scandal; but it was only when *Private Eye* published them in 1992 that action started to be taken. When the unit was finally staffed properly in 1995 with careful monitoring of results, the death rates came tumbling down from 29 percent to 4 percent in two years.

A key lesson from Bristol was that a vital step to a safe NHS was accurate, publicly available comparative data on death across the service, combined with a duty to investigate higher-than-expected death rates quickly and thoroughly. This message was later reinforced by the Shipman Inquiry in 2002, where a single GP managed to disguise hundreds of deaths over many years. Dame Janet Smith, who chaired the inquiry, recommended death rates be accurately monitored across the NHS and any statistical outliers swiftly investigated.

In hospitals, at least, Standardised Mortality Ratios (HSMRs) have been measured since the mid-1990s, and published annually by Dr Foster since 2001, in collaboration with Professor Brian Jarman and Paul Aylin at Imperial College. A score above 100 is higher than expected. The 1998-99 HSMR for Mid Staffs was 108. The HSMRs from 2001-02 to 2007-08 were all significantly high. These figures were in the public domain, available to all who cared to look. The Department of Health and successive Labour health secretaries (Alan Milburn; John Reid; Patricia Hewitt; Alan Johnson; and Burnham) should have been monitoring and discussing them with their NHS chief executives (until September 2006 Sir Nigel Crisp; then Nicholson).

High death rates are common in the NHS, and can be caused by a hospital having sicker patients, "miscoding" their diseases or providing poor quality care. A high HSMR is a warning sign that has to be investigated to find the root causes. There

are plenty of good examples of hospitals responding to high death rates and staff concerns, and improving care as a result. So what happened in Mid Staffs?

Fix the data, not the problem

In April 2007, Mid Staffs' HSMR was 127 – one of the highest in the country. The Labour government, the DoH, the strategic health authority, primary care trusts and health regulators should all have known this. In addition, a series of more specific mortality alerts — indications that patients may be exposed to greater than expected risk — were issued to Mid Staffs.

On 3 July 2007, the Dr Foster Unit at Imperial College sent Martin Yeates, the Mid Staffs boss, a mortality alert for operations on the jejunum (small bowel). Over the next four months the unit issued three further mortality alerts concerning aortic, peripheral, and visceral artery aneurysms; peritonitis and intestinal abscess; and other circulatory disease. Copies of three of these mortality alerts went to the Healthcare Commission (now the Care Quality Commission).

Chris Turner, who worked in the emergency department at Stafford Hospital in October 2007, described it to the public inquiry as "an absolute disaster". Staff were threatened almost daily that they would lose their jobs if they did not get patients through the department within the four-hour target, he claimed. The result was "significant numbers of patients in distress and, as a department, we were immune to the sound of pain". On 5 December 2007 a meeting was held between Monitor and Mid Staffs for its application for foundation trust status. Monitor was told: "Our HSMR is currently 101: we do not have a problem with mortality."

So how did Mid Staffs manage to fix its figures without fixing the problem of appalling care? The 101 figure turned out to be a screenshot of the only point in time when Mid Staffs death rate approached 100.

Dr Phillip Coates, the trust's clinical governance lead, told the inquiry that the party line was that there was a "coding problem" and also a "problem with the Dr Foster/Jarman methodology". "Instead of acknowledging that patients may have been dying unnecessarily and trying to identify what we should do about it, our reaction was that we needed to find some way to get the figure lower and we started taking the view that it came down to a coding problem."

In March 2007, the Department of Health under Nicholson had relaxed the rules on palliative care coding, meaning any patient who had an "incurable illness" could be given the palliative care code, rather than those genuinely at the end of life under a palliative care consultant. This had enabled a private coding company, CHKS, to go to Medway hospital in Kent and work wonders overnight by coding many patients as "expected to die" and therefore on the palliative care route.

Brian Jarman has shown that exactly the same happened one year later at three trusts in the West Midlands – David Nicholson's old patch, including Mid Staffs. Overnight, palliative care deaths had risen to 35 percent of deaths at Mid Staffs, making it the largest hospice in the UK but without any of the compassion. And the mortality ratio had gone down to a much "healthier" level.

Change the diagnosis

Another way to reduce mortality alerts is to change the diagnosis. Patients come in with a fractured hip, and the longer the delay in operating, the more likely they will die, often from pneumonia. But if they have the pneumonia longer than the fractured hip, their primary diagnosis can be recoded as the former, and they vanish from the hip fracture mortality alerts.

Using this method, the number of people dying after fracturing their femur at Mid Staffs fell from 87 percent to 40 percent, even though the number of people dying didn't change. This entirely legal recoding was overseen at Mid Staffs by Texan coder Sandra Haynes Kirkbright (pictured). She had a philosophy degree and had learned how to "code" patients in the American insurance model of care.

Haynes Kirkbright recalls meeting HSMR guru Brian Jarman. "I said: 'I think you're going to see a change in the HSMR'; and he said: 'Coding can't change the HSMR'. I went: 'OK it can't'. But it totally can."

By 2009, a patient with a hip fracture was seemingly five times less likely to die if admitted to Mid Staffs than to the average English hospital, and Mid Staffs was seemingly one of the five "most improved" trusts for HSMR reduction in the country. And it might have got away with it, had it not been for the pesky Healthcare Commission.

'All that is wrong with NHS management'

The belated Healthcare Commission investigation, which reported in 2009, was triggered by complaints from Julie Bailey and Cure the NHS, and helped by local journalist Shaun Lintern.

It was led by fearless investigator Heather Wood, whom the Care Quality Commission later attempted to gag. Writing in the *British Medical Journal (BMJ)*, Wood describes Mid Staffs as a symptom of a serious underlying illness in the NHS. "In all the investigations involving acute hospitals that I led on behalf of the Healthcare Commission, we found clear evidence of poor care on general wards, even when the focus was specifically on, for example, outbreaks of *Clostridium difficile*. Where some poor care may, arguably, stem from a fault line in the training of nurses, we found evidence that the poor care and failure to control infection were related to the determination of managers to drive through financial restraint and achievement of targets."

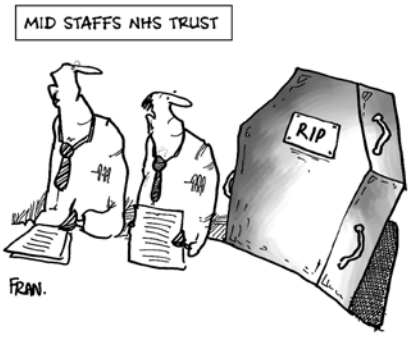
Wood has all the evidence that Mid Staffs was certainly not a one-off and could still be happening elsewhere, and believes that a change of culture in the NHS can only happen with a change of leadership.

BMJ joins the denial

The *BMJ* has recently printed some excellent analysis of Mid Staffs – but at the time it misjudged events.

On the day the Healthcare Commission report finally exposed Mid Staffs in 2009, for example, the *BMJ* chose to publish a paper from Birmingham University questioning the validity of using death rates to identify poor quality care, by authors who were already known to be deeply sceptical about them.

Prof Jarman, of Imperial College, has no problem with academics challenging his work openly and fairly. But the research was commissioned by West Midlands strategic health authority, and senior employees from the SHA and Mid Staffs trust were on the steering committee for the research – a clear competing interest the *BMJ* chose not to declare as such. The *BMJ* also agreed with the authors' request to publish on the same day as the damning Healthcare Commission report, leading editor Fiona Godlee to ask: "Was the *BMJ* used as part of a concerted effort to discredit the HSMR?" A *BMJ* investigation decided "No." As Francis observed: "The University of Birmingham reports, though probably well-intentioned, were distractions. They used the Mid Staffordshire issue as a context for discrediting the Dr Foster methodology." Roger Davidson, head of external affairs at the Healthcare Commission at the time, said in evidence to the public inquiry that the publication in the *BMJ*, on the day the commission planned to publish an investigation into Mid Staffs, "looked to me like a planned attempt at a spoiler".



"Well, if the patient representative has nothing to add, we can move on to the fantastic success of the revised mortality measurements..."

This *BMJ* paper may have had the effect of not just pushing Mid Staffs further into denial, but giving other NHS hospitals with high death rates an excuse for not investigating thoroughly.

Why Nicholson won't go

Nicholson should be held to account over Mid Staffs, but he was carrying out the orders of his political masters. The political imperative was always to bury the bad news with the patients, silence dissent and deliver only good news to Downing Street.

As Sir Ian Kennedy observed in Bristol, too much power in the NHS is concentrated in the hands of too few people, which is both unhealthy and dangerous.

David Nicholson is seen as indispensible both by those on the political left, who trust the former Communist Party member not to betray his roots and sell the NHS off to the market, and those on the right because he sticks to budget. His predecessor Sir Nigel Crisp resigned over a £600m overspend (less than 1 percent of the NHS budget at the time). Nearly 1,200 patients have died unnecessarily in one hospital alone, and probably many more thousands across the NHS, and yet to make Nicholson responsible would be to accept that the hugely disruptive market reforms he has enacted for Labour and the Coalition are also at fault.

Nicholson has had seven years in office and his management style simply isn't suited to the compassionate, open, devolved, fear-free safety culture the NHS needs. There are plenty of gifted senior managers in the NHS (or from outside) more suited to the job. He recently disclosed that he has diabetes and is one of 700,000 NHS employees struggling with their weight. He should step down, get fit – and sit on a local Healthwatch board to learn how powerless the patient voice is. Then he should do what the politicians most fear: publish his memoirs.

Over the years Nicholson has enacted reforms to the NHS he clearly thought were bollocks; but he has collected a very decent salary, pension, expenses and a knighthood for his troubles. Now the fixer has been found out, he could finally blow the lid on the damage constant political meddling does to the health service. But does he have the courage?

M.D.