North Bristol
NHS Trust

# Lesson from the Mid Staff Inquiry

**Sean Collins, BSc (Hons), PG Cert.**
**Adult Safeguarding Lead**
**North Bristol NHS Trust**

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# Workshop Aims

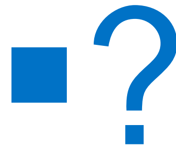
- To explore what happen at this hospital
- What went wrong
- What is the solution

# Definition of an Institution

1. An organisation founded for a religious, educational or social purpose
    1. Synonyms  organisation,, establishment, institute, foundation centre

2. An established law or practice
    1. Practice custom, phenomenon, fact, procedure, convention, usage, tradition, rite, fashion, use, habit

# Can a perpetrator be an organisation



FOUNDATION
TRUST KILLED OUR
LOVED ONES
WHERE
NEXT
WHY HAS IT
TAKEN SO LONG
400 DEATHS
Lack of genera
pain relief

Joan Giles

# STAFFORD HOSPITAL: A DAMNING DIAGNOSIS

POOR CARE RESPONSIBLE FOR 400-1,200 DEATHS

£13 MILLION INVESTIGATION LED TO 290 RECOMMENDATIONS

CULTURE OF 'FEAR, BULLYING AND SECRECY'

PATIENTS LEFT IN EXCREMENT-STAINED BED

COMMUNICATION FAILURE AT 'EVERY LEVEL'

PATIENTS 'LEFT TO SCREAM IN AGONY' AMID STAFF 'CHAOS'

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THE MID STAFFORDSHIRE
NHS FOUNDATION TRUST
PUBLIC INQUIRY

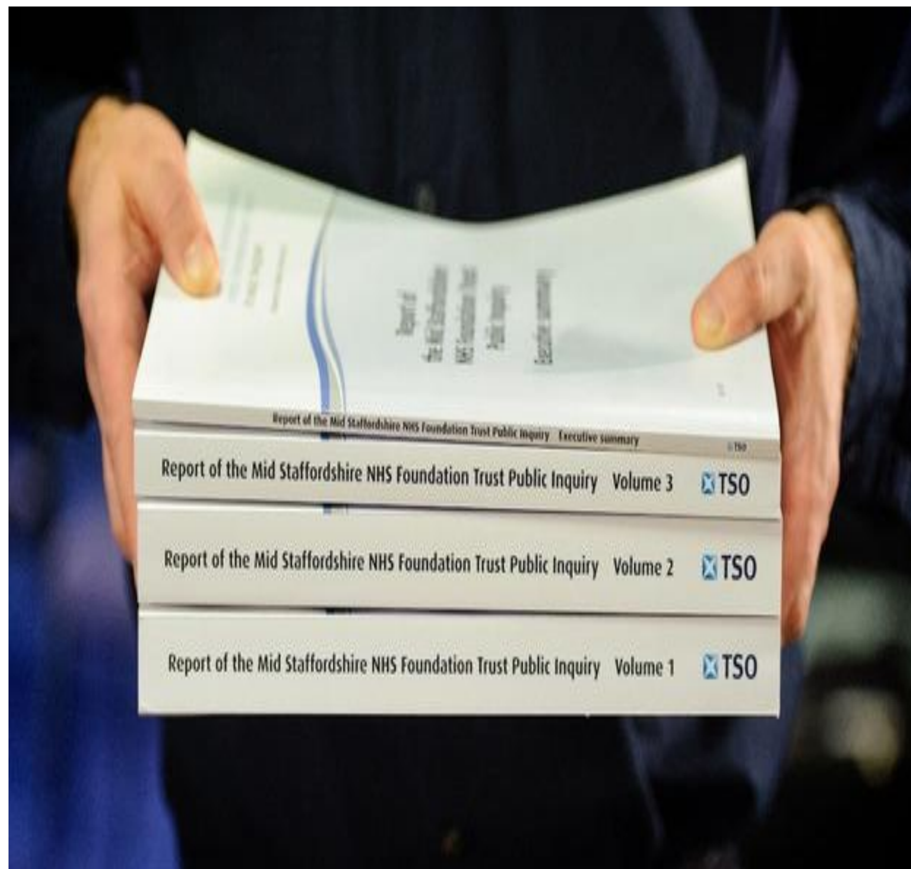
Chaired by Robert Francis QC

**Report of
The Mid Staffordshire
NHS Foundation Trust
Public Inquiry**

**Volume 1:
Analysis of evidence and
lessons learned (part 1)**

HC 898-I

3 Volumes
not to be sold
separately



# Organisational/Institutional Abuse

- Organisational abuse – including neglect and poor care practice within an institution
- or specific care setting such as a hospital or care home, for example, or in relation to
- care provided in one's own home. This may range from one off incidents to on-going
- ill-treatment. It can be through neglect or poor professional practice as a result of the
- structure, policies, processes and practices within an organisation.

- Neglect and poor professional practice also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as institutional abuse

# The History!

- **2005-2008:** reports of failings at Mid Staffordshire NHS Foundation Trust emerge
- **March 2009:** Healthcare Commission publishes report of its investigation
- **24 February 2010:** Robert Francis QC publishes report of independent inquiry
- **9 June 2010:** Andrew Lansley announces a full public inquiry into the failings at Mid-Staffordshire NHS Foundation Trust

# Timeline

- **8 November 2010:** Public inquiry opens
- **6 February 2013:** Robert Francis QC publishes the inquiry's final report
- **26 March 2013:** Government publishes its initial response *Patients First and Foremost* and commissions further reviews of patient safety, bureaucracy, complaints and
- **19 November 2013:** Government publishes its full response to the Francis Inquiry, *Hard Truths – the journey to putting patients first*



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# The Francis Review

- Published 6th Feb 2013 (for this presentation all the reviews are spoken of together)
- Totals 1918 pages !!!!!!
- 290 recommendations
- "Building on the report of the first inquiry, the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care"

# Exercise 1

- In your tables can you try and work out what a list of indicators that should of warned the hospital and others of the problem would look like?
- In effect I'm asking what were the problems
- 5/10 mins

# The Warning Signs (structural)

- Lose of the Star rating in 2004 Trust went from 3 stars to 0.
- Peer Reviews; Cancer Peer Review (2005) Care of the Critically Ill and Critically Injured Children Review (2006). Raised concerns about the Trusts ability to deliver a safe service.
- HCC Review (2006)
- The HCC commissioned annual surveys of staff and patient opinion conducted by the Picker Institute. The results of the survey taken for the previous year were published in about April the following year. The 2007 inpatient survey, while identifying many areas in which the Trust did well or performed satisfactorily, in several areas rated the Trust as being in the worst performing 20% in the country.

- Whistleblowing; It is clear that a staff nurse's report in 2007 made a serious and substantial allegation about the leadership of A&E.
- Royal College of Surgeons Report (Jan 2007)
- Lords Francis View
- "….. The above is only part of the story demonstrating the warning signs that were emanating from the Trust during this period and the corresponding reaction from external agencies. An examination of the evidence the Inquiry has heard reveals a pattern of concerns which, taken together, and in some cases even singly, such as certain examples of the systemic failure to deliver proper care to one patient, showed that there were serious systemic issues at the Trust requiring a degree of urgent and effective attention which they were not receiving"

# The Warning Signs (clinical )

- As a result of poor leadership and staffing policies, a completely inadequate standard of nursing was offered on some wards in Stafford. The complaints heard at both the first inquiry and this one testified not only to inadequate staffing levels, but poor leadership, recruitment and training. This led in turn to a declining professionalism and a tolerance of poor standards. Staff did report many incidents which occurred because of short staffing, exhibited poor morale in their responses to staff surveys, and received only ineffective representation of concerns from the RCN.

- Consultants at Stafford were not at the forefront of promoting change. The Inquiry heard evidence which added justification to the view formed at the first inquiry that clinicians did not pursue management with any vigour with concerns they may have had. Many kept their heads down. A degree of passivity about difficult personnel issues is all too common in the NHS as, perhaps, elsewhere. However, a system that is safe for patients requires a much more rigorous approach. The Trust lacked a sufficient sense of collective responsibility or engagement for ensuring that quality care was delivered at every level.

- Trust management had no culture of listening to patients. There were inadequate processes for dealing with complaints and serious untoward incidents (SUIs). Staff and patient surveys continually gave signs of dissatisfaction with the way the Trust was run, and yet no effective action was taken and the Board lacked an awareness of the reality of the care being provided to patients. The failure to respond to these warning signs indicating poor care could be due to inattention, but is more likely due to the lack of importance accorded to these sources of information.

# Exercise 2

- Why did the system fail?
- On your tables please consider why the system did not work? Why were these problems not identified?
- 5/10 mins

- It is clear from the evidence at both inquiries that the Trust was operating in an environment in which its leadership was expected to focus on financial issues, and there is little doubt that this is what it did. Sadly, it paid insufficient attention to the risks in relation to the quality of service delivery this entailed.
- There was an unacceptable delay in addressing the issue of shortage of skilled nursing staff. There can be little doubt that the reason for the slow progress in the review, and the slowness of the Board to inject the necessary funds and a sense of real urgency into the process, was the priority given to ensuring that the Trust books were in order for the FT application. The result was both to deprive the hospital of a proper level of nursing staff and provide a healthier picture of the situation of the financial health of the Trust than the true reality, healthy finances being material in the achievement of FT status. While the system as a whole appeared to pay lip service to the need not to compromise services and their quality, it is remarkable how little attention was paid to the potential impact of proposed savings on quality and safety.

- It is a significant part of the Stafford story that patients and relatives felt excluded from effective participation in the patients' care. The concept of patient and public involvement in health service provision starts and should be at its most effective at the front line.
- Analysis of the patient surveys of the Trust conducted by the HCC and the Picker Institute shows that they contained disturbing indicators that all was not well from long before the intervention of the HCC.

# Why things were not discovered sooner

- The negative aspects of culture in the system were identified as including:
- A lack of openness to criticism
- A lack of consideration for patients
- Defensiveness
- Looking inwards not outwards
- Secrecy
- Misplaced assumptions about the judgements and actions of others
- An acceptance of poor standards
- A failure to put the patient first in everything that is done.
- It cannot be suggested that all these characteristics are present everywhere in the system all of the time, far from it, but their existence anywhere means that there is an insufficiently shared positive culture.

"To change that, there needs to be a relentless focus on the patient's interests and the obligation to keep patients safe and protected from substandard care. This means that the patient must be first in everything that is done: there must be no tolerance of substandard care; frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations.

# What did Francis say should happen?

- Putting the patient first the NHS Constitution
- Simplifying regulation
- Monitoring of compliance with fundamental standards
- Enforcement of compliance with fundamental standards
- Accountability of board level directors
- Caring, compassionate and considerate nursing
- Effective complaints and incidents
- Enhanced quality standards for commissioning
- Real involvement of patient and the public in all that is done
- Openness transparency and candour

# Exercise 3

- What has been learnt from the Mid staff scandal?
- On your tables can you come up with a series of measures that would help tackle the issues uncovered?

(please focus on what the organisation could do rather then the “bigger system”)

# What has been learnt?

Some respondents found the public inquiry report of "challenging" and "unhelpful" length and that the recommendations lacked prioritisation. The problems uncovered are not however amenable to simplistic, one-off solutions. Therefore it is inevitable that widespread change was called for. To the extent that there is a consensus around the Inquiry recommendations, whatever their number, it is surely incumbent on leaders at all levels to devise programmes for their implementation and an order of priority.

Undertaking the necessary culture change in the NHS was never going to be easy or a short one-off task. Only time will tell whether the obvious enthusiasm for change demonstrated by hospitals taking part in this research, can translate into the relevant action. Regular reviews will be needed to monitor progress.

- DoH accepted nearly all the recommendations
- Lots of been done
- The NHS Constitution

## Values in the NHS Constitution

### WORKING TOGETHER FOR PATIENTS

Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

### RESPECT AND DIGNITY

We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

### EVERYONE COUNTS

We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

### COMMITMENT TO QUALITY OF CARE

We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

### COMPASSION

We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

### IMPROVING LIVES

We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

- Inspection regimes (CQC) have been tightened the inspection regime changed (Inspectors by experience)
- Commissioning Standard with regard quality are now wide spread.
- Quality Surveillance groups now exist
- Duty of Candour now in professional code of conduct
- Registration of Health Care Support works under review
- Chief Nursing Officers 6 C for nursing

| Initiatives and reviews relating to the quality of hospital care 2012/3 | | |
|---|---|---|
| **Bureaucracy and regulatory review, carried out by the NHS Confederation** | November 2013 | Government-commissioned review of bureaucracy and the burden of information collection |
| **Report of handling of complaints by NHS hospitals in England, by Ann Clwyd MP and Professor Tricia Hart ('NHS hospitals complaints system review')** | October 2013 | Government-commissioned review of hospital trusts' handling of complaints |
| **National Patient Safety Advisory Group in England, chaired by Professor Don Berwick ('Berwick review into patient safety')** | August 2013 | Government-commissioned review of safety |
| **Review into the quality of care and treatment provided by 14 hospital trusts in England, led by Sir Bruce Keogh ('Keogh mortality review')** | July 2013 | Government-commissioned review of 14 hospital trusts that had been persistent outliers on measures of mortality |
| **Independent review into health care assistants and support workers in the NHS and social care settings, chaired by Camilla Cavendish ('Cavendish report')** | July 2013 | Government-commissioned review of health care assistants |
| **Review of aggregate assessment of providers of health and social care in England, carried out by the Nuffield Trust ('Ratings review')** | March 2013 | Government-commissioned review of the viability of rating hospitals and other providers |
| **'Compassion in Practice: Nursing, midwifery and care staff: Our vision and strategy', carried out by Jane Cummings, Chief Nursing Officer for England, and Viv Bennett, Director of Nursing, Department of Health and Lead Nurse, Public Health England** | December 2012 | Chief Nursing Officer/NHS England vision and strategy document for nursing and other care staff |

# 6Cs - Values essential to Compassionate

## Care

Care is our core business and that of our organisations; and the care we deliver helps the individual person and improves the health of the whole community.

Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life

## Compassion

Compassion is how care is given through relationships based on empathy, respect and dignity.

It can also be described as intelligent kindness and is central to how people perceive their care

## Competence

Competence means all those in caring roles mist have the ability to understand an individual's health and social needs

It is also about having the expertise, clinical and technical knowledge to deliver effective dare and treatments based on research and evidence

## Communication

Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say. It is essential for 'No decision without me'.

Communication is the key to a good workplace with benefits for those in our care and staff alike

## Courage

Courage enables us to do the right thing for the people we care for, to speak up when we have concerns.

It means we have the personal strength and vision to innovate and to embrace new ways of working

## Commitment

A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients.

We need to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead

# Some thoughts? (personal not the views of NBT)

- The phrase "adult safeguarding" does not appear anywhere in the reviews nor is there any consideration of the needs for adult safeguarding. Is there a role for adult safeguarding
- Most quality of care indicators are clinically based rather than experiential
- There were no prosecutions. Will the Corporate Manslaughter and Corporate Homicide Act 2007 make a difference.
- Perhaps the Criminal Justice and Courts Act 2015 will make a difference (although MHA and MCA offences were in place
- Culture will always beat System

- Whistleblowing and the NHS
- Speaking out champions
- Swartz rounds
- How do we measure professional culture?

# Culture will always beat System

# The most important question?

- Could this happen again?