The Mid Staffordshire NHS Foundation Trust Inquiry

Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009

Volume I

Chaired by Robert Francis QC

HC375-I

Return to an Address of the Honourable the House of Commons
dated 24 February 2010

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Chaired by Robert Francis QC

5 February 2010

Dear Secretary of State

In accordance with the terms of reference that you set for this Inquiry, I submit my report.

When I first visited Stafford, having been appointed to chair the Inquiry, I was asked by Julie Bailey what it could bring out that she and her fellow members of Cure the NHS did not know already. I think it is clear that my investigation has unearthed a considerable amount of material that will be useful in helping not only Mid Staffordshire NHS Foundation Trust, but also the wider NHS, learn from the appalling experiences suffered by such a large number of people. The overwhelming number of accounts given by those affected should surely put to rest the views, still harboured by some, that the Healthcare Commission's report painted an unfair picture of how the Trust was performing. There can no longer be any excuse for denying the enormity of what has occurred.

While the number of staff who came forward to assist my Inquiry was disappointing, it is right that their experience and viewpoint should be recorded. Throughout the course of my Inquiry, it has become apparent that many staff, during the period under investigation, did express concerns about the standard of care being provided. The tragedy was that they were ignored.

The Inquiry has also had the benefit of hearing, and being able to report, the views and thinking of many former and current directors of the Trust. It is clear that many of the problems suffered in this Trust had been in existence for a long time and were known about by those in charge. Many thought – and still think – that they had done their best to address them. While there is no doubt that steps were taken to address many, if not all, of the problems, sadly the action taken was insufficient. I suggest that the board of any trust could benefit from reflecting on their own work in the light of what is described in my report.

The Inquiry has also been able to give some consideration to the complex issue of mortality statistics, and my report offers a contribution to what must be a continuing debate. The Inquiry heard and has reported the many concerns expressed about the role that external agencies play in the oversight of the provision of healthcare. There is undoubtedly further work to be done not only at the Trust, but elsewhere, before public confidence can be assured. Various views have been expressed on whether the Trust is unique or whether other similar stories wait to be uncovered. It is not for me to express a view on that, but the legitimate concerns of those who have suffered in Stafford do need to be addressed.

Since the arrival of the new executive team, much encouraging work appears to have been done and I hope that this report will be a useful tool to help in that process. A degree of caution should be deployed, given the continuing concerns raised with me about some areas; it is surely not too much to hope that the Trust will soon be able to regain the confidence of its local community. Many of the witnesses who gave evidence were motivated because they do care about the hospital, and demonstrated by their actions that they can be a part of mending the fractured confidence I spoke of when the Inquiry opened.

I have made a number of recommendations that I hope will help Mid Staffordshire NHS Foundation Trust and the wider NHS improve the safety and quality of care it provides to its patients. I hope you and your colleagues will accept and build on them.

If there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experiences that lie behind statistics and benchmarks and action plans that really matter, and that is what must never be forgotten when policies are being made and implemented.

Yours sincerely

Robert Francis QC

Chairman

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Executive summary

Introduction

The purpose of the Inquiry

1. Concerns about mortality and the standard of care provided at the Mid Staffordshire NHS Foundation Trust resulted in an investigation by the Healthcare Commission (HCC) which published a highly critical report in March 2009. This was followed by two reviews commissioned by the Department of Health. These investigations gave rise to widespread public concern and a loss of confidence in the Trust, its services and management.

2. This Inquiry was set up by the Rt Hon Andy Burnham MP, Secretary of State for Health, primarily to give those most affected by poor care an opportunity to tell their stories and to ensure that the lessons to be learned from those experiences were fully taken into account in the rebuilding of confidence in the Trust. The period reviewed by the Inquiry was principally January 2005 to March 2009.

3. The terms of reference also allowed the Inquiry to gather the views and experience of the staff at the Trust and to seek explanations from management, including the directors, for what happened. It was not the intention that the Inquiry should be a forum for bringing individuals to account but the opportunity has been taken to examine the processes of accountability.

4. There has been considerable public concern about the significance of the mortality statistics which prompted the HCC's investigation. The Inquiry undertook a consideration of the significance to be attached to these figures.

5. The Inquiry was urged to investigate the role of a number of external agencies in the failure to detect and act on the deficiencies revealed by the HCC investigation, but the terms of reference set did not permit it to do so. It has, however, received a considerable body of opinion on that issue.

Methodology and material considered

6. The Inquiry Chairman invited assistance from a panel of specialist advisers and had the benefit of advice and submissions from Counsel to the Inquiry. Cure the NHS, a group representing the vie ws of a number of patients and their families with complaints about the Trust, was invited to contribute to the Inquiry as an interested party. Its legal representatives were accorded observer status at hearings, as were representatives of the Trust, the Primary Care Trust (PCT) and

the strategic health authority (SHA). Observers were only permitted to be present at a hearing when the witness attending agreed. All hearings were held in private, but summaries of the evidence heard were posted regularly on the Inquiry's website.[1]

7. Documentary material was obtained from a wide variety of sources, including the Trust, the PCT and other NHS bodies, the Care Quality Commission (successor to the HCC), the SHA, Monitor, Cure the NHS, the local authorities and the four local Members of Parliament, who had all been approached by constituents with concerns.

8. When the Inquiry was set up, it was envisaged that it would have the benefit of reports on individual cases that had been reviewed by the independent case notes review being conducted under the auspices of the PCT. It emerged that the review was not expected to complete its work until March 2010 and therefore outside the timescale of this Inquiry. It was, however, possible to receive copies of notes and, in some cases, records of interviews with patients and their families from the review, where those seeking the review consented.

9. The Inquiry was contacted, directly or indirectly, by 966 individual members of the public and some 82 members of Trust staff, past and present. The majority of the members of public expressed concerns about the care received and observed at the Trust, but a substantial minority had only positive comments to make. The Inquiry also received representations from a wide range of organisations, including professional bodies and patient interest groups.

10. It was not possible for the Inquiry to see all those who had contacted it at an oral hearing. The general themes arising out of the written material were identified and a selection made of cases that appeared illustrative of a theme, or raised points of particular interest, required clarification or for some other reason would assist the Inquiry in its task. Members of staff, past and present – including a number who had not contacted the Inquiry, were also invited to attend oral hearings. These included executive and non-executive directors who had been in post during the period under review.

11. With one exception, all those members of staff who were invited to attend an oral hearing did so. The exception was Mr Yeates, the former Chief Executive, who I was satisfied on medical evidence, including independent medical advice commissioned by the Inquiry, was unfit to attend. However, some written material was furnished on his behalf. In total, the Inquiry heard oral evidence from 113 witnesses.

[1] http://www.midstaffsinquiry.com

General approach

12. It was not the intention of the Inquiry to re-investigate the findings of the HCC, but it has been necessary to look at some of the areas the HCC considered. The report is not intended to cover every area considered in the HCC report but has been led, to a significant extent, by the evidence the Inquiry has received. The intention has been to look at sufficient areas to enable a picture to be developed of the deficiencies that have been suffered by patients during the period under review and the systemic failings which led to them.

13. In addition to considering the detail of the stories of those who gave oral evidence, it was thought essential that the accounts given to the Inquiry by all who had concerns about the care provided should be acknowledged and summarised in the report to provide a record from which all who read it could learn and promote acceptance of the true scale of the deficiencies at the Trust. Therefore, a separate and substantial volume is devoted to summaries of the accounts received of concerns from the members of the public who made contact with the Inquiry.

14. In general, individuals have not been identified in the report to protect their privacy and rights to confidentiality, but Board members, past and present, are identified.

The patient experience

15. The Inquiry received complaints about care in many parts of Stafford Hospital and occasionally at Cannock Chase Hospital. The complaints were predominantly focused on the accident and emergency (A&E) department, the emergency assessment unit (EAU) and Wards 7, 8, 10, 11, and 12. It was striking how many accounts related to basic nursing care as opposed to clinical errors leading to injury or death.

16. In very few cases did the Inquiry hear from members of staff about their recollection of or explanations for the specific incidents recounted by patients and their families. This was not an adversarial process in which the truth and reliability of witnesses was tested as would have occurred in a traditional 'trial'. Nonetheless, the quality of the evidence given by patients and their families, the dignity and care with which they did so, and the sheer number of similar accounts was highly persuasive. There is no reason to doubt that in the vast majority of cases events occurred as they have been described. Many of the complaints had been made to others before the HCC report was published and therefore were not affected by its influence. The evidence was quite sufficient to establish that what we heard provided a fair account of the standards of care being provided at the times described.

17. The experience of listening to so many accounts of bad care, denials of dignity and unnecessary suffering made an impact of an entirely different order to that made by reading written accounts. All those who were present at oral hearings were deeply affected by what they heard. One of the purposes of setting out summaries not only of the oral accounts but also of the written accounts received in volume 2 has been to assist in the understanding of what occurred, and to promote good standards of care in the future. It is hoped that it will also provide a public acknowledgement of the important contribution to the Inquiry made by these witnesses and to allow their voices to be heard by those with responsibility for delivering care at these and other hospitals. This material should also assist the Trust's staff, individually and collectively, to acknowledge and accept that the care provided in the past often fell far below an acceptable standard.

18. The areas in which detailed accounts were heard by the Inquiry included:

- continence and bladder and bowel care;
- safety;
- personal and oral hygiene;
- nutrition and hydration;
- pressure area care;
- cleanliness and infection control;
- privacy and dignity;
- record keeping;
- diagnosis and treatment;
- communication; and
- discharge management.

Continence and bladder and bowel care

19. Of the 33 cases of which oral evidence was heard, 22 included significant concerns in this category. Requests for assistance to use a bedpan or to get to and from the toilet were not responded to. Patients were often left on commodes or in the toilet for far too long. They were also often left in sheets soiled with urine and faeces for considerable periods of time, which was especially distressing for those whose incontinence was caused by *Clostridium difficile*. Considerable suffering, distress and embarrassment were caused to patients as a result.

20. There were accounts suggesting that the attitude of some nursing staff to these problems left much to be desired. Some families felt obliged or were left to take soiled sheets home to wash or to change beds when this should have been undertaken by the hospital and its staff. Some staff were dismissive of the needs of patients and their families.

21. The omissions described left patients struggling to care for themselves; this led to injury and a loss of dignity, often in the final days of their lives. The impact of this on them and their families is almost unimaginable. Taken individually, many of the accounts I received indicated a standard of care which was totally unacceptable. Together, they demonstrate a systematic failure of the provision of good care.

22. The causes of these instances of poor care included, in a small number of cases, staff who appeared uncaring. More often there were inadequate numbers of staff on duty to deal with the challenge of a population of elderly and confused patients. There may also have been a lack of training in continence care and difficulties may have been compounded some of the time by infection control problems. It is difficult to believe that lapses on the scale that was evidenced could have occurred if there had been an adequately implemented system of nursing and ward management.

Safety

23. The Inquiry received striking evidence about the incidence of falls, some of which led to serious injury. Many, if not all, took place unobserved by staff and too many were not reported to concerned relatives for too long, or only when they saw an injury for themselves. Recording of falls was of questionable accuracy. The Inquiry heard of an instance of a patient suffering a series of falls unobserved, finally sustaining a fatal injury.

24. Confused patients can be a threat to themselves and others in their ward. The Inquiry heard evidence of threats and even assaults by such patients taking place before any intervention by staff.

25. The reason for the incidence of falls and other safety concerns was probably attributable to a combination of a high dependency level among the mix of patients combined with too few staff, or staff not sufficiently qualified to cope. Incidents of the type described to the Inquiry should not have been able to happen or continue more than momentarily if proper risk assessment and observation were applied.

Personal and oral hygiene

26. The Inquiry heard of many cases in which relatives had to spend extended periods attending to their relatives' hygiene needs. This included having to get the patient to and from the bathroom, washing, and attending to other personal care needs. Little assistance was offered in such cases, and there was a fear that if families did not attend to such care the staff would not do so. The accounts included cases of patients who had soiled themselves who were dependent on their relatives to clean them.

27. The evidence included complaints about the poor hygiene practice of staff when they did attend to the washing of patients. Bad practice observed included using a razor on more than one patient, and the use of a shared bowl for washing. The Inquiry heard several accounts of poor mouth care in which mouthwash was not provided for patients with mouth ulcers, and neglect of basics such as cleaning teeth and rinsing out of dried mouths. A particular concern for a number of elderly female patients was the failure, in some cases, to wash and brush patients' hair.

28. Failure to ensure a proper level of personal cleanliness and hygiene degrades patients, aggravating the feelings of illness, disability and separation from home and familiar surroundings. A wholly unacceptable standard was tolerated on some of the Trust's wards for a significant number of patients.

Nutrition and hydration

29. About half the patients and their families who gave oral evidence provided accounts of issues with obtaining appropriate food and drink. The concerns raised included:

- lack of menus;
- provision of inappropriate food for patients' conditions;
- failure to provide a meal;
- meals placed out of reach and taken away without being touched;
- patients not helped to unwrap the meal or cutlery;
- patients not encouraged to eat;
- relatives and others denied access at mealtimes;
- visitors having to assist other patients with their meals;
- visitors prevented from helping feeding;
- water not available at the bedside;
- water intake not encouraged or monitored;
- drips not monitored adequately; and
- monitoring and appropriate records of fluid balance not maintained.

30. The provision of food and water is one of the most basic responsibilities of a hospital and its staff. Patients are often unable to provide for themselves. Each patient requires individual consideration. The deficiencies observed in the evidence were not confined to one ward or period. Frequently the explanation appears to have been a lack of staff, but sometimes staff were present but lacked a sufficiently caring attitude. There was evidence of unacceptable standards of care as a result of systemic failings. What has been shown is more than can be explained by the personal failings of a few members of staff.

Pressure area care

31. Some 20 people who contacted the Inquiry complained of bad experiences with pressure sores. Their stories suggested a lack of care; these stories were not surprising given the general description of care afforded at times. Shortage of staff and other obstructions made it inevitable that there would be cases of avoidable skin breakdown. It is doubtful whether assessment techniques were used consistently, and there seems to have been little multidisciplinary team working.

Cleanliness and infection control

32. Many witnesses remarked on the lack of appropriate cleaning in wards and facilities resulting in patients being left in a dirty state. There was also evidence of poor hygiene practice, including using the same cloth to clean ward surfaces and toilets. Hand gel containers were often left empty. Rooms vacated by patients with C. difficile were not cleaned before the next patient was admitted. Witnesses also complained of a lack of information about what precautions should be taken. The evidence heard by the Inquiry suggests that the deficiencies identified have not been isolated mistakes or lapses restricted to one place or one time.

Privacy and dignity

33. Many of the accounts of the patient experience at the Trust described clearly impacted on patients' dignity. There were notable causes for concern which included:

- incontinent patients left in degrading conditions;
- patients left inadequately dressed in full view of passers-by;
- patients moved and handled in unsympathetic and unskilled ways, causing pain and distress;
- failures to refer to patients by name, or by their preferred name; and
- rudeness or hostility.

34. However difficult the circumstances, there is no excuse for staff to treat patients in the manner described by some witnesses to the Inquiry. Respect for dignity must be a priority of care and must be at the forefront of clinicians' minds.

Record keeping

35. The Inquiry has examined a wide range of medical records and has heard from patients and their families of concerns they had about record keeping. A number of common deficiencies were observed, including:

- no clear registration of patients' transfer from one ward to another;
- no consistent use of care plans;
- incomplete nursing records;
- lack of appropriate nutrition and hydration charts;
- sparse details of social history, past medical history and other important background information;
- authors of records not clearly identifying themselves;
- failure to record assessment scores; and
- inaccurate recording of time of death.

36. A number of relatives told of how they altered or completed records themselves on finding inaccuracies.

Diagnosis and treatment

37. The Inquiry heard of a number of cases of clear misdiagnosis, including a case of a failure to diagnose a serious injury in a young man who later died as a result. There were also cases involving delayed diagnosis. In some cases, families were not listened to during the diagnostic process. The Inquiry heard of failure to follow up investigations and a lack of communication between staff about what needed to be done. The manner of communicating serious diagnosis to patients sometimes left a lot to be desired. A common complaint was of a long wait between assessments and the communication of a diagnosis.

38. Mistakes in diagnosis are inevitable sometimes. Whether or not they are avoidable, they are always likely to be detrimental to the patient and knowledge of the mistake will add to his or her distress.

Communication

39. A very significant number of patients gave accounts of poor standards of communication; the concerns raised included:

- lack of compassion for patients or lack of reassurance that staff cared;
- lack of information about patients' care or condition;
- lack of involvement in decisions;
- insensitivity;
- reluctance to give information;
- failure of communication between staff;
- provision of wrong information;
- failure to listen; and
- lack of engagement with families and friends.

40. The provision of the right information to patients and their families at the right time is vital. This requires staff to possess it, and pass it on to colleagues to ensure continuity and consistency. Information needs to be delivered with sensitivity and due regard for the patients as valued individuals.

Discharge management

41. Patients and their families complained to the Inquiry in 96 cases about matters connected with discharge from hospital. The principal issues raised have been:

- discharge from A&E without appropriate diagnosis or management;
- premature discharge from wards;
- protracted discharge processes;
- failure to communicate arrangements to patients and their families;
- discharge at an inappropriate time or in an inappropriate condition; and
- failure to ensure adequate support.

42. There is an impression that community support services may not be entirely satisfactory, but the burden of the complaints raised matters that can and should be addressed within a hospital. The pressure to discharge patients from wards to accommodate the patient intake from A&E should not be allowed to be a factor in influencing the decisions of managers and clinicians to discharge patients who are not ready. Adequate arrangements and warning of discharge must be provided. Any waiting area designed for discharged patients should be properly equipped to cater for their needs.

The culture of the Trust

43. The culture of the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff. A number of factors contributed to this:

- **attitudes of patients and staff** – patients' attitudes were characterised by a reluctance to insist on receiving basic care or medication for fear of upsetting staff. Although some members of staff were singled out for praise by patients, concerns were expressed about the lack of compassion and uncaring attitude exhibited by others towards vulnerable patients and the marked indifference they showed to visitors.
- **bullying** – an atmosphere of fear of adverse repercussions in relation to a variety of events was described by a number of staff witnesses. Staff described a forceful style of management (perceived by some as bullying) which was employed on occasion.

- **target-driven priorities** – a high priority was placed on the achievement of targets, and in particular the A&E waiting time target. The pressure to meet this generated a fear, whether justified or not, that failure to meet targets could lead to the sack.
- **disengagement from management** – the consultant body largely dissociated itself from management and often adopted a fatalistic approach to management issues and plans. There was also a lack of trust in management leading to a reluctance to raise concerns.
- **low staff morale** – the constant strain of financial difficulties, staff cuts and difficulties in delivering an acceptable standard of care took its toll on morale and was reflected by absence and sickness rates in particular areas.
- **isolation** – there is a sense that the Trust and its staff carried on much of its work in isolation from the wider NHS community. It was not as open to outside influences and changes in practice as would have been the case in other places and lacked strong associations with neighbouring organisations.
- **lack of openness** – before obtaining Foundation Trust status, the Board conducted a significant amount of business in private when it was questionable whether privacy was really required. One particular incident concerning an attempt to persuade a consultant to alter an adverse report to the coroner has caused serious concern and calls into question how candid the Trust was prepared to be about things that went wrong.
- **acceptance of poor standards of conduct** – evidence suggests that there was an unwillingness to use governance and disciplinary procedures to tackle poor performance. The Inquiry has heard of particular incidents of apparent misconduct which were not dealt with appropriately, promptly or fairly.
- **reliance on external assessments** – The evidence indicates that the Trust was more willing to rely on favourable external assessments of its performance rather than on internal assessment. On the other hand when unfavourable external information was received, such as concerning mortality statistics, there was an undue acceptance of procedural explanations.
- **denial** – In spite of the criticisms the Trust has received recently, there is an unfortunate tendency for some staff and management to discount these by relying on their view that there is much good practice and that the reports are unfair.

The experiences and perceptions of staff

Accident and emergency

44. A&E was chronically understaffed in terms of consultants and nurses during the period under review. There were frequent changes in management, which led to a sense of lack of leadership and support of staff. The perception of weak clinical leadership within A&E held by some was unfair to one consultant on whom undue burdens were placed. When more consultants were recruited to ease the pressure,

they were emergency physicians who were not qualified to undertake the whole range of A&E duties. The drive to meet the waiting time target had a detrimental effect on staff and on the standard of care delivered. There was persuasive evidence that this even led to attempts to fabricate records.

Emergency assessment unit

45. The evidence from patients and their families presented a mixed picture of the EAU, but staff consistently described the ward in pejorative terms. The pressure of working there was felt by some to be intolerable.

Other wards

46. Staff evidence tended to confirm the concerns raised by patients and their families. Among difficulties described were problems in locating a nurse to accompany ward rounds, the pressure from high-dependency patients and the dilution of skills that resulted from reconfiguration. Understaffing was a constant problem and staff even expressed fear about losing their registration because of the unsafe care delivered. Concerns were also expressed about the inappropriate mix of patients on the surgical floor.

The management of significant issues

47. The Inquiry has examined how particular issues were dealt with by management.

Ward reconfiguration

48. Staff perceived this scheme, to reconfigure the wards onto three floors, one surgical and two medical, as a means to reduce costs and staff. This was denied by those who proposed the scheme, but it is significant that at the time the initial proposal was approved savings were prominently identified. The minutes of the Board suggest that finance was a crucial factor. It was acknowledged by all concerned that the success of the scheme was dependent on achieving the correct levels of staffing.

49. There does not appear to have been an evidence base for the changes that were made. The attraction of the advantages – the financial savings – discouraged proper attention being paid to the disadvantages. The EAU was established as part of the first part of the reconfiguration project. Many who worked there regarded the level of staffing as inadequate, a view not shared by the Director of Clinical Standards. The surgical floor was set up without any evidence that a risk assessment of the necessary changes was actually carried out, although the need for it was recognised. Concerns expressed by staff at the time about the proposal were welcomed by directors but were not addressed.

50. The Inquiry could not trace any record of the medical floors part of the plan being considered or approved by the Board. In particular, the changes of nursing skill mix, which resulted in a predominance of healthcare assistants over qualified nurses, are not recorded in any Board minute seen by the Inquiry. There were differences of account between executive directors as to who was involved in the decision and the change was disowned by the Director of Clinical Standards, and only nurse on the Board, in evidence to the Inquiry. There was a concerning lack of clarity about the process by which this important decision was taken.

51. Once implemented, the medical floors scheme met with widespread disapproval from staff. The evidence strongly suggests that the whole clinical floors project was planned and implemented without due regard to staff's legitimate concerns and without monitoring by the Board of the effectiveness of the scheme once implemented.

Finance

52. Much of management thinking during the period under review was dominated by financial pressures. The Trust had been facing financial problems for some time before the period under review, with frequent annual deficits. However, a crisis developed at the end of the 2006/07 financial year which led to a need to find cuts of £10 million. It is by no means clear that the only way of finding the necessary savings was to implement a workforce reduction programme. It certainly need not have happened without the involvement of staff and the various departments. Instead, a top-down proposal was launched with departments having to identify cuts to fit the predetermined budget.

Implementation of staff cuts

53. The Trust has yet to recover fully from the impact of the staff cuts and changes to skill mix. When these changes were made, the Trust did not have sufficient information about the funded establishment to enable properly informed decisions to be taken. The workforce reduction proposal in 2006 was accompanied by what was called a risk assessment, but on the documents seen by the Inquiry this was superficial and inadequate. The minutes of the Hospital Management Board do not suggest that there was any detailed scrutiny of how the assessment was performed and of its significance. It is also unclear what, if any, engagement executive directors had in this process. When there was a change in Directorship of Clinical Standards/Nursing in December 2006, the new incumbent immediately recognised the need for a workforce review. When completed, it became clear that far from being overstaffed at the time of the workforce reduction the Trust had been understaffed with nurses.

Workforce review

54. The review, the need for which was identified in December 2006, was not completed until March 2008. No satisfactory explanation has been given for why it took so long. Even when the findings of the review were received the Board did not react to it with great urgency, seeking to fund the necessary increase in staff in stages, which are still incomplete. The ramifications of this in terms of the standard of care it was possible to deliver appear not to have been sufficiently appreciated.

Governance

55. In 2002, the Commission for Health Improvement (the predecessor of the HCC) reported that the Trust lacked effective clinical governance. This had not been corrected by the beginning of the period under review. The new Chair who arrived in August 2006 understood this deficiency existed and the need to remedy it. Part of her solution was to pursue Foundation Trust status as a driver for improvements in governance. The structure had several layers of management between divisional governance groups and the Board. The Medical Director and the Director of Nursing were the only two routes through which clinical or nursing concerns were likely to reach the Board. Higher level committees focused on financial matters and did not appear to have been receiving or addressing clinical issues as a priority.

56. Clinical audit was poorly developed at the Trust. Many individual clinicians were reluctant to engage in it and there was a lack of resources and support for those who did.

57. Incident reporting systems were criticised by many staff, in particular because of the lack of feedback and because reports attributing incidents to staffing issues were perceived to be discouraged. These factors led some staff to be reluctant to file incident reports. There was, at least for a time, a lack of clarity about the requirements for filing a serious untoward incident report. The Inquiry found evidence that a number of deaths which led to inquests had not been reported in this system when they should have been.

58. The investigation of complaints was frequently delegated to staff in the area with which the complaint was concerned. This could result in defensive rather than constructive reports which lacked credibility with complainants who perceived them to lack impartiality. Replies to complaints were often provided too slowly and did not always address all the issues raised. There was a formulaic approach which appeared to value process over substance. Apologies when offered were not always well thought out. Staff who were the subject of complaints did not always have the full details put to them, devaluing any investigation.

59. A particularly disturbing feature of the complaints process was that the Trust often did not apply effective remedial action. This is evidenced by a series of complaints raising similar issues in which the response each time was an action plan which, if implemented, would have avoided a subsequent incident. It is difficult to understand how the Chief Executive, if he read the complaints, could have been unaware of systemic failings in the delivery of care. Some letters acknowledged multiple failings. There is no evidence that the substance of complaints were reported to the Board. If they had been told of some of the experiences of those who complained, they would not have been as shocked as they were when finally members of Cure the NHS were able to speak to them directly.

60. A poor complaints system has a negative impact on the patients and others who seek to use it. Inadequate responses cause distress and may exacerbate bereavement. Complainants are left desperate for answers to their questions. While the Board received reports of themes of complaints, these were too broad to be informative. With a serial filtering of information with no involvement from non-executive directors, the Board was distanced from the reality of complaints.

61. Appraisal and professional development were accorded a low priority, as indicated by national surveys. There was evidence that staff were not supported by a robust appraisal system and that continuous professional development was sporadic. There was also evidence of a reluctance to take robust disciplinary action where this appeared to be needed. Concerning cases of alleged misconduct and deficient performance have either not been addressed at all or only in a hesitant manner. This is starkly evidenced by two Royal College of Surgeons' reviews of the hospital's surgical division and the dysfunction brought to light by them.

62. The few instances of reports by whistleblowers of which the Inquiry was made aware suggest that the Trust has not offered the support and respect due to those brave enough to take this step. The handling of these cases is unlikely to encourage others to come forward, and the responses to the investigation of the concerns raised have been ineffective.

The Board

63. The Inquiry examined the experience of Board members during the period under review together with their explanations of what happened and their reactions to the HCC report. It also examined the process leading up to the departure of the Chair and Chief Executive in March 2009. It was noted that the non-executive directors recruited by the Trust were on the whole inexperienced in NHS board positions. While this may be inevitable in a relatively small trust, it does give rise to a need to call on more training or outside assistance.

64. The codes of conduct and guidance for directors make it clear that their duty is to provide strategic direction and that they should refrain from intervening in operational detail, but that they are collectively accountable for all aspects of the performance of the Trust. The Board may have interpreted the division between the strategic and the operational too rigidly, particularly at a time when they were aware that there were serious deficiencies in the governance structure. They may have failed to understand that in such circumstances there will be many instances when a non-executive director can only understand the issues by being informed of operational detail.

65. The styles and characteristics of various Board members may help to explain how they functioned as a group. The Chair throughout the relevant period was a strong leader with a clear vision admired by her colleagues. The clinicians taking the role of medical director were reluctant recruits to part-time posts. They may have been handicapped in presenting the professional view to the Board by the disinclination of consultants to engage with management issues. They were not natural leaders and lacked an external perspective which might have alerted them more readily to issues about standards. The registered nurse who had the post of Director of Clinical Standards was unpopular with staff and lacked the confidence of the Chair and was replaced. Her successor may have had a disadvantage in coming from a trust which would have offered fewer challenges and greater support. She was able, however, to demonstrate to the Inquiry that she was conscientious and able to work out what needed to done, although she may have found prompt implementation difficult to achieve. The Director of Operations gave an impression of having focused on individual tasks, such as the achieving of targets, at the expense of leading the overall operation of the Trust.

66. The non-executive directors, including the Chair, had an appreciation that there were serious deficiencies in certain areas of the Trust's operation. The Chair provided a list of them to the Inquiry. The other non-executives supported her to set about remedying these by the replacement of the Chief Executive. Likewise, the Director of Nursing who arrived in December 2006 appreciated that there were serious nursing issues to be addressed. In spite of that appreciation, too often the initiation of a process such as the appointment of a new chief executive or the setting up of a new governance structure was regarded as sufficient and the executive could then be left to get on with things. Remedial action has often not been pursued with the vigour and urgency warranted by the situation.

67. The Inquiry examined the clinical floors project and the Board's management of this issue. The Board approved this without an adequate examination of the implications. While placing reliance on the advice of the Executive Director who was the architect of the project, little attention was paid to any other opinion, and little attempt was made to engage front-line staff. There was no adequate impact or risk assessment and, once set in motion, no proactive assessment of how it

was working. Their approach was symptomatic of a passive style from which challenge and engagement with the key issues was absent.

68. With regard to the Board's approach to workforce reduction, this was agreed at a time of maximum financial pressure when there may have been no alternative to staff cuts. However, assurances were too readily accepted as to the safety of the proposals and there was little challenge evident. When the deficiencies were appreciated as a result of the commencement of the skill mix review, this was not progressed with the speed required by the circumstances.

69. The application for Foundation Trust status was pursued by the Board in part as a means of furthering the need for improvement in governance structures rather than ensuring that the Trust was in a genuinely fit state for the application before embarking on it. There may have been external encouragement to seek Foundation Trust status, but it remained the Board's duty to ensure that it was an appropriate step to take. The pressures of the process are likely to have distracted the Board from other tasks. The Inquiry does not accept that the Board set out to deceive anyone with the application, but their declarations in relation to the quality of care provided at the Trust revealed a profound misunderstanding of their responsibilities. The focus seems to have been on processes not outcomes.

70. The Board did not engage with the public as it should have done; in particular, it conducted more business than was appropriate in private. The Board's reaction to the HCC report was individually and collectively one of denial instead of searching self-criticism. The most common reaction among directors was that the report was unfair because it did not adequately reflect the progress that had been made. During the investigation itself, a degree of complacency was shown and there continued to be a lack of urgency in seeking solutions to the problems identified.

71. Although the Chief Executive between January 2005 and March 2009 was not medically fit to attend the Inquiry, documentary material was obtained from which his response to the criticisms of the HCC report could be gleaned, as could the process leading to his departure from the Trust. He asserted that he had been appointed to a failing trust and had achieved a turnaround of the organisation by putting in place a sustainable future, robust governance, and improving quality and standards of care. He considered that the high mortality figures were attributable to coding issues, and that skill mix issues had been identified and were being addressed. Acknowledging that there was work to do, he described the Trust's culture as being inwardly focused and complacent, resistant to change and accepting of poor standards. He considered the HCC report to be unfair. Whatever Mr Yeates may have believed at the time of his departure, in reality the issues raised in this report had not been remedied. He focused on systems, not their outcomes. There was a need for senior management to be deeply involved in service delivery until they could be satisfied that the systems were actually

working. He did successfully get to grips with some issues, but the concerns described by both him and his Chair were largely the same as those discerned by the current Chief Executive on his arrival. This does not suggest a successful period of management.

72. The Chair was asked to leave by the Chair of Monitor on the publication of the HCC report. While such a termination is efficient in the sense that it allows the Trust to move on under new management, it is unsatisfactory that there is no process of accountability which allows for a fair determination of the performance of the individual as against the standards and codes of conduct to be expected of someone in such an important public position.

73. The Chief Executive stepped aside before being formally suspended by the Board which then commissioned an external report into his performance. Although the report recommended that there was a prima facie case for disciplinary action, the Board decided on pragmatic and commercial grounds to negotiate terms for an agreed departure. The result was that the Chief Executive was also forced out of office without any determination of whether his own performance was in breach of any relevant standards or the code of conduct. There was no public accountability of the type that would be expected in the case of, for instance, a doctor.

Mortality statistics

74. The Inquiry has looked at the Hospital Standard Mortality Ratio (HSMR) and the ways in which the hospital death rates are compared with each other. The HSMR for the Trust was significantly higher than the average. It was these figures which attracted the attention of the HCC and caused it to launch its investigation. There are a number of sources for such figures, some of them run as a commercial operation. The methodology and significance of these statistics are subject to academic controversy. Taking account of the range of opinion offered to the Inquiry, including a report from two independent experts, it has been concluded that it would be unsafe to infer from the figures that there was any particular number or range of numbers of avoidable or unnecessary deaths at the Trust. However, there is strong evidence to suggest that these figures mandated a serious investigation of the standards of care being delivered rather than reliance on the contention that they had been caused by coding.

External organisations

75. The Inquiry has received a considerable number of representations that there should be an investigation into the role of external organisations in the oversight of the Trust. Concern is expressed that none of them from the PCT to the Healthcare Commission, or the local oversight and scrutiny committees, detected anything wrong with the Trust's performance until the HCC investigation. While

such an investigation is beyond the scope of this Inquiry, local confidence in the Trust and the NHS is unlikely to be restored without some form of independent scrutiny of the actions and inactions of the various organisations to search for an explanation of why the appalling standards of care were not picked up. It is accepted that a public inquiry would be a way of conducting that investigation, but also accepted that there may be other credible ways of doing so.

Conclusions & Recommendations

76. The deficiencies in staff and governance began before the period under review and were recognised by the management. Any trust where there have been long-term serious organisational challenges will be difficult to turn around. However, the action taken by management to address many of the issues they identified was ineffective. Many of the problems found by the Chair on her arrival in 2004 were still present when the current Chair and Chief Executive took over in 2009.

77. A theme of the evidence about the Board has been reliance on the distinction between strategic and operational issues and a disclaimer of responsibility for the latter. The distinction does not justify directors not interesting themselves in operational matters when it is known that governance systems are either not in place or are untested. There was also a lack of clarity about responsibilities for nursing issues.

78. The Board's approach to some problems such as governance was characterised by a lack of urgency. The issues identified in this report required constant follow-up, review and modification. It was unacceptable that the staff review should have been allowed to take so long to complete and implement.

79. A common response to concerns has been to refer to generic data or benchmarks such as star ratings, rather than the experiences of actual patients. While benchmarks and data-based assessments are important tools, these should not be allowed to detract attention from the needs and experiences of patients. Benchmarks, ratings and status may not always bring to light serious systemic failings.

80. Among other themes the Inquiry has identified from the evidence are:

- a corporate focus on process at the expense of outcomes;
- a failure to listen to those who have received care through proper consideration of their complaints;
- staff disengaged from the process of management;
- insufficient attention to the maintenance of professional standards;

- lack of support for staff through appraisal, supervision and professional development;
- a weak professional voice in management decisions;
- a failure to meet the challenge of the care of the elderly through provision of an adequate professional resource. Some of the treatment of elderly patients could properly be characterised as abuse of vulnerable persons;
- a lack of external and internal transparency;
- false reassurance taken from external assessments; and
- a disregard of the significance of the mortality statistics.

Recommendations

Recommendation 1: The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard.

Recommendation 2: The Secretary of State for Health should consider whether he ought to request that Monitor – under the provisions of the Health Act 2009 – exercise its power of de-authorisation over the Mid Staffordshire NHS Foundation Trust. In the event of his deciding that continuation of foundation trust status is appropriate, the Secretary of State should keep that decision under review.

Recommendation 3: The Trust, together with the Primary Care Trust, should promote the development of links with other NHS trusts and foundation trusts to enhance its ability to deliver up-to-date and high-class standards of service provision and professional leadership.

Recommendation 4: The Trust, in conjunction with the Royal Colleges, the Deanery and the nursing school at Staffordshire University, should review its training programmes for all staff to ensure that high-quality professional training and development is provided at all levels and that high-quality service is recognised and valued.

Recommendation 5: The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.

Recommendation 6: The Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this report and ensure that it:

- provides responses and resolutions to complaints which satisfy complainants;
- ensures that staff are engaged in the process from the investigation of a complaint or an incident to the implementation of any lessons to be learned;
- minimises the risk of deficiencies exposed by the problems recurring; and
- makes available full information on the matters reported, and the action to resolve deficiencies, to the Board, the governors and the public.

Recommendation 7: Trust policies, procedures and practice regarding professional oversight and discipline should be reviewed in the light of the principles described in this report.

Recommendation 8: The Board should give priority to ensuring that any member of staff who raises an honestly held concern about the standard or safety of the provision of services to patients is supported and protected from any adverse consequences, and should foster a culture of openness and insight.

Recommendation 9: In the light of the findings of this report, the Secretary of State and Monitor should review the arrangements for the training, appointment, support and accountability of executive and non-executive directors of NHS trusts and NHS foundation trusts, with a view to creating and enforcing uniform professional standards for such posts by means of standards formulated and overseen by an independent body given powers of disciplinary sanction.

Recommendation 10: The Board should review the management and leadership of the nursing staff to ensure that the principles described in the report are complied with.

Recommendation 11: The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on matters relating to the standard and safety of the service provided to patients.

Recommendation 12: The Trust should review its record-keeping procedures in consultation with the clinical and nursing staff and regularly audit the standards of performance.

Recommendation 13: All wards admitting elderly, acutely ill patients in significant numbers should have multidisciplinary meetings, with consultant medical input, on a weekly basis. The level of specialist elderly care medical input should also be reviewed, and all nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion.

Recommendation 14: The Trust should ensure that its nurses work to a published set of principles, focusing on safe patient care.

Recommendation 15: In view of the uncertainties surrounding the use of comparative mortality statistics in assessing hospital performance and the understanding of the term 'excess' deaths, an independent working group should be set up by the Department of Health to examine and report on the methodologies in use. It should make recommendations as to how such mortality statistics should be collected, analysed and published, both to promote public confidence and understanding of the process, and to assist hospitals to use such statistics as a prompt to examine particular areas of patient care.

Recommendation 16: The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified.

Recommendation 17: The Trust and the Primary Care Trust should consider steps to enhance the rebuilding of public confidence in the Trust.

Recommendation 18: All NHS trusts and foundation trusts responsible for the provisions of hospital services should review their standards, governance and performance in the light of this report.

Introduction

1. This Inquiry was set up by the Rt Hon Andy Burnham, MP, Secretary of State for Health, when he announced in a written statement[2] made on 21 July 2009 that he had appointed me to chair an independent inquiry into Mid Staffordshire NHS Foundation Trust. The terms of reference were as follows:

   - *to investigate any individual case relating to the care provided by Mid Staffordshire NHS Foundation Trust between 2005 and 2008 that, in its opinion, causes concern and to the extent that it considers appropriate;*
   - *in the light of such investigation, to consider whether any additional lessons are to be learned beyond those identified by the inquiries conducted by the Healthcare Commission, Professor Alberti and Dr Colin-Thomé; and, if so,*
   - *to consider what additional action is necessary for the new hospital management to ensure the Trust is delivering a sustainably good service to its local population; and*
   - *to prepare and deliver to the Secretary of State a report of its findings.*

2. The Secretary of State also announced that it was planned for my report to be submitted by the end of the year. He stated that if I considered that I needed powers to compel the attendance of witnesses, then he had the power to convert the Inquiry under the Inquiries Act 2005.

3. By a letter dated 10 September 2009,[3] the Secretary of State agreed to amend the terms of reference so that the period to be reviewed ended in March 2009, which is when the report of the Healthcare Commission (HCC) was published. He declined to convert the Inquiry into an inquiry under the Inquiries Act 2005. At the same time he declined to extend the scope of the Inquiry to include an investigation of the role of the relevant primary care trusts and strategic health authority or the various regulators and oversight organisations. I understand that this decision may be the subject of judicial review proceedings, but this has not prevented me from proceeding with the Inquiry as established to address the terms of reference set by the Secretary of State.

4. Subsequently, on 26 October, the Secretary of State granted my request to extend the time for the submission of my report to the end of January 2010.

[2] The full statement is at Appendix 1
[3] Appendix 2

Events leading to the setting up of the Inquiry

5. The matters giving rise to concern will be considered in detail in the body of this report, I should note here the investigations that have preceded the Inquiry. In 2007, concerns were raised about the Trust's mortality rate as compared with other similar trusts. In particular the Dr Foster Unit issued a series of alerts, and in April 2007 the Dr Foster Hospital Guide showed that the Trust had a higher than expected Hospital Standardised Mortality Ratio for 2005/06. In October 2007 the Trust was assessed as 'good to fair' in the HCC's 2006/07 annual health check. In February 2008 the Trust's application for foundation trust status was granted by Monitor, the body charged by Parliament with granting foundation trust status and overseeing such trusts once they are set up. In April 2008 the HCC launched an investigation into the Trust following what it regarded as a concerning reaction by the Trust to the mortality statistics. The HCC's investigation turned out to be protracted. In March 2009 it published the report of its investigation, which was highly critical of the acute care provided by the Trust. Very shortly before the publication of the HCC's report, the Chair and Chief Executive of the Trust left office in circumstances which I will examine in more detail later in this report.

6. During the course of the investigation and following the publication of the HCC's report, there was an increasing public outcry led by a group of patients and patients' relatives who had had experiences of poor care at the hands of the Trust. Calling itself Cure the NHS, this group was led by Julie Bailey. The daughter of Isabella Bailey, an elderly patient who died in Stafford Hospital, Ms Bailey was concerned and aggrieved by the care that she saw being provided there. She launched the campaign with a letter to the Staffordshire Newsletter in December 2007, and the Cure the NHS group ensured that the issue of the standard of care provided by the Trust remained in the public consciousness. The group mounted a campaign for a public inquiry into the failings, as it saw them, not only of the Trust's management but also of the wider NHS and its regulatory framework.

7. In a partial response to these publicly expressed concerns, over the course of 2009 the Trust set up an independent case notes review. This was initially led by Dr Laker, to whom anyone concerned about the care or outcome of care provided to themselves or a deceased relative could apply for a review. After the public expressed dissatisfaction at the lack of independence and effectiveness of this review, control of it was passed to the primary care trust, which has managed it ever since. My terms of reference and the associated ministerial announcements envisaged that the Inquiry would be able to take account of the findings of the independent case notes review. In fact, it emerged that the work of the review was not sufficiently advanced for this to be possible within the timescale for the Inquiry that was laid down by the Secretary of State. However, subject to the consent of the complainants being obtained, I have had access to the medical notes and the records of interviews held by the review, and have from time to time received an updated analysis of the types of cases and concerns involved in

the cases under review. I have been told that the review is not expected to be completed until at least March 2010.

8. The Secretary of State commissioned his own reviews: by Dr Colin-Thomé on the lessons to be learned in relation to commissioning of services and by Professor Alberti on the specific issues surrounding emergency admissions at Stafford Hospital. Both prepared reports that were published at the end of April 2009.

9. None of these reviews or reports satisfied the public concerns as represented by Julie Bailey and Cure the NHS, who continued to demand a public inquiry. Ministers have continued to refuse to allow a public inquiry. Their reasons can be summarised by reference to what Ben Bradshaw MP, then Minister of State for Health Services, said to the House of Commons in a debate on 18 May 2009:[4]

   I can understand that there are many who consider that a public inquiry into the events at Mid Staffordshire is both appropriate and necessary. A number of people have recalled the Bristol heart babies inquiry. In our view the critical difference is that that inquiry was initiated when, under the previous Conservative Government, there was no independent watchdog or regulator for the NHS.

   The whole point of establishing the Commission for Health Improvement in 2000 and the subsequent regulators since was to provide the public with the confidence that any concerns that they might have about NHS care in their areas would be properly and independently investigated. I have not heard any criticism of the Healthcare Commission's investigation or any suggestions that it did not get to the bottom of what went wrong at Stafford hospital. Given that, as well as the two subsequent inquiries and the action flowing from them, the Government remain unconvinced at this time that a public inquiry would add anything to our understanding of what went wrong or of what needs to be done to prevent such terrible events from happening again.

10. However, he said that ministers remained open to representations.[5]

11. In its report published on 3 July 2009, the Health Select Committee said:[6]

    Regarding Mid-Staffordshire Trust, we are unconvinced of the case for a full public inquiry into the Trust, given the work that has already been done by the HCC, Professor Sir George Alberti and Dr David Colin-Thomé, and the likely further disruption to the Trust. However, we do see merit in the idea, recommended to us by the Royal College of Nursing, of holding hearings in private to allow members

[4] Hansard, HC (series 5) vol 492, col 1279 (18 May 2009)
[5] Ibid. col 1280
[6] House of Commons Health Committee (July 2009) *Patient Safety*, para 296, London: TSO

of staff to give evidence confidentially to discover how the state of affairs progressed so far without detection by the Trust Board. As this would look at the past and involve those in post in previous years, it would not impede the process of improvement and the rebuilding of confidence in the hospital. Although held in private its findings should be made public with protection of individual witnesses as appropriate.

12. While the view of the current ministerial team about a public inquiry remains the same, as can be seen from the announcement of this Inquiry and the subsequent letter referred to above,[7] the Secretary of State did decide to set up this Inquiry. He stated his reasons in his written statement of 21 July 2009:

It is clear from listening to those affected that rebuilding local confidence and restoring trust will take time. The full impact of what happened at Mid-Staffordshire is revealed through the personal stories of those affected and it is clear to me that these experiences need to be properly aired if the local NHS is to learn and, in time, move on.

I have therefore decided, following detailed discussions between my department and the new management of the trust, that it would be appropriate to set up a further independent inquiry. I do not believe it is necessary for this to be a full public inquiry, given the thoroughness of the reports already produced by the Healthcare Commission, Professor Sir George Alberti and David Colin-Thome, as well as the availability of an Independent Clinical review to those who have concerns about the care they or a loved one received at the hospital.

This inquiry's focus will be on ensuring that patients or their families have an opportunity to raise their concerns. It is important, given the events of the past, for those who depend upon the care provided by the trust to be confident that they have been listened to and that any further lessons not already identified by the thorough inquiries that have already occurred be learned.

Inquiry support

13. I decided not to seek the appointment of a panel to sit with me. Accordingly it has remained my sole responsibility to produce this report. However, I am a practising barrister and while I have experience in medico-legal matters I am not an expert in many of the issues that this Inquiry must consider. Therefore I have sought the assistance of a number of independent expert advisers. I have also been assisted by an inquiry team which includes a Secretary and Counsel to the Inquiry.[8]

[7] Appendices 1 and 2

[8] A list of the expert advisers and the principal members of the Inquiry team appears at Appendix 3

Role of Counsel to the Inquiry

14. The role of Counsel to the Inquiry was to assist me in identifying the relevant issues, and in the analysis of the evidence to examine witnesses at oral hearings and to provide legal advice. He was invited to make opening and closing statements. Insofar as those statements contain opinions, they were his own, and I was free to adopt or reject them as I saw fit. It was not part of his duty to advance any particular case but to assist me in the process of the Inquiry.

Role of expert advisors

15. As with Counsel the advisers' role was to assist me with the assessment of the evidence and its significance and provide me with the benefit of their expertise. On occasions some of them attended oral hearings, and all have had access to the written material. I have consulted them as I thought appropriate on the content of this report in relation to matters falling within their expertise, and have taken their views into account. They have seen a draft of the report and none dissent from the conclusions I have drawn. However the conclusions of this report are mine and mine alone, and they have no responsibility for them.

Private nature of the Inquiry

16. Cure the NHS made forceful representations to me that I should hold the Inquiry in public, even though it was not a 'public' inquiry in the sense of being an inquiry under the Inquiries Act 2005. I received written representations from some members of the public to the same effect. The principal reasons given were that those most affected by what had happened at Stafford Hospital were entitled to be able to see and hear Trust management account for what had happened; they could not be satisfied that there had been a proper and rigorous inquiry unless it was in public; and the public had a right to know what had happened and why. It was also argued that the Inquiry would be better informed if its process was in public, because the publication of evidence as it was given would allow others to comment on it more freely. On the other hand, the Health Select Committee, chaired by the Rt Hon Kevin Barron MP, endorsed the view of the Royal College of Nurses that an inquiry hearing evidence in private would encourage members of staff to give evidence in confidence in order to find out why what happened was not detected by the Trust Board.

17. In the course of my preliminary consideration of the material available to me, it became clear that there were likely to be many members of hospital staff, both past and present, who would be very reluctant to give evidence to me at a public oral hearing. Some were likely to be afraid of the reaction of colleagues, and others of the reaction of the Trust and its management. While some no doubt wished to avoid the stress of an appearance in the glare of publicity.

18. That such fears existed was confirmed by various encounters I had with staff. For example there were some clinical and nursing staff who made themselves known to the Inquiry who made it clear that they were prepared to provide information but not at an oral hearing held in public. Indeed, some were only prepared to be interviewed somewhere other than at the Inquiry's premises. As a result, I and members of my team had to see some witnesses in premises elsewhere, or even in their homes. Whether such fears or reluctance were justified, I am confident that many of the witnesses who have assisted the Inquiry by written or oral evidence would not have done so had the Inquiry been conducted in public.

19. I also held a series of meetings for staff at the hospital, further described below. Some of these were attended by a very small number. It was clear to me that some of those, in particular nursing staff, were very hesitant to express views which they feared might be considered disloyal to their employer, if those views came to the Trust's attention. A phrase commonly used was *"I cannot believe I am saying this"*. Again, such individuals would have been most unlikely to attend a public hearing.

    - Members of the Trust management who might have been regarded as responsible for what went wrong, professional staff concerned about what regulatory action might be taken against them, and others potentially open to criticism, were likely be reluctant to attend an open hearing. That this was a correct judgement was confirmed by the significant number of such witnesses who were not prepared to agree to observers being present while they gave evidence.
    - A principal intended purpose of the Inquiry was to record the experiences and views of the patients and their families. Such evidence was inevitably concerned with sensitive and confidential medical information, and matters that were very distressing for those involved to talk about at all – let alone on a public stage. I thought it likely that a significant number of such witnesses would not agree to give evidence in public, or in some cases come forward at all. Again, in my view that judgement was confirmed by the significant number of such witnesses who refused to have observers present while they gave evidence, including, perhaps surprisingly, some who were or had been members of Cure the NHS.
    - I considered it likely that some witnesses, unused to appearing in public and distressed or under stress as a result, would be unlikely to give as full an account of their experience in public as they would at a sympathetically arranged private hearing.

20. Given these anticipated difficulties, I was satisfied that to hold all oral hearings in private would maximise the prospects of obtaining candid and full evidence from the greatest number of potential witnesses. I considered whether I should hold some hearings in public and some in private, but concluded that this would

involve considerable administrative difficulty, and might also put undue pressure on some of the more reluctant and nervous witnesses and deter some from cooperation.

21. I believe that these expectations have proved to be correct. Patients and their families were, as will be seen, remarkably swift to contact the Inquiry; where asked, to consent to the disclosure to me of confidential records; and, where invited, to attend a private oral hearing. Fewer staff came forward than desirable, but all those invited to attend a private oral hearing agreed to do so, with one exception. The evidence they gave, as will be seen, was in many cases remarkable for its candour and openness in its criticism of the service provided at the hospital.

22. I have sought to mitigate the exclusion of the public from the hearings in three principal ways:

- I invited certain interested parties to appoint observers to attend oral hearings, subject to the agreement of the witness attending. These parties were the Trust, the primary care trust, the strategic health authority and Cure the NHS. The observers were required to give an undertaking to keep confidential the names of witnesses and any other information from the evidence which would be likely to identify the witness, however they could pass on the gist of what they heard to the interested party they represented. In the case of Cure the NHS, its solicitors sent representatives as observers on its behalf and on behalf of the witnesses they represented. The solicitors were supplied for their internal professional use with copies of the transcripts of the evidence given at those hearings they attended.
- Summaries of the evidence given at oral hearings were prepared by the Inquiry team and published on the Inquiry website.
- Transcripts of the opening and closing statements made Counsel to the Inquiry and interested parties were also published on the website.

Evidence and material received

23. A large quantity of documentary material was obtained from a variety of sources:

- Material from the Trust regarding its management and governance, including but not limited to material covering complaints; serious untoward incidents; Board and committee minutes covering the period under review; details of the foundation trust application; and actions since the publication of the HCC's report.
- Material was obtained from Monitor regarding the Trust's application for foundation trust status.

- The Care Quality Commission produced material that the HCC had gathered during the 2008/09 investigation, including correspondence with the Trust concerning the investigation; records of interviews with staff and patients (subject to consent); extracts of drafts of their report; minutes relating to changes in the statistical information; and Trust management and other records.
- The local Members of Parliament, David Kidney MP (Stafford), Bill Cash MP (Stone), Sir Patrick Cormack (South Staffordshire) and Dr Tony Wright MP (Cannock Chase) gave the Inquiry access to material and complaints sent to them by constituents, having obtained their consent for such disclosure.
- The independent case notes review gave the Inquiry access to the medical records and interview notes of cases under review where appropriate consents had been obtained. 141 individuals were content to share their material with the Inquiry.
- Members of the public sent correspondence and other material directly to the Inquiry.
- Cure the NHS provided correspondence and notes of cases from its members past and present.
- Documentation was offered by Stafford Borough Council, the strategic health authority and the coroner.
- Representations were received from other organisations.[9]
- Reports and literature that were in the public domain.

Direct engagement

24. Contact was made with 17 local third sector organisations, as well as Staffordshire County Council Adult Social Care Services and Cannock Chase District Council. Thirteen advertisements were placed in local papers advertising information sessions and giving details on how to provide evidence to the Inquiry. Coverage also appeared in the editorial sections of local newspapers and on local radio.

25. The Inquiry wrote to all foundation trust members – current and former members of staff (over 4,000 people in total) – to seek their views and experiences of patient care and working at Stafford Hospital.

26. The Inquiry team gave opportunities for the public to make contact with the Inquiry by pre-advertised attendance at five information sessions held in different locations in Stafford and Cannock during October 2009. Approximately 60 members of the public attended these events and many subsequently offered relevant information or made statements.

27. A series of meetings were held at the hospital to enable staff to meet me and/or other members of the Inquiry team and to express views on an informal basis.

[9] A list of the organisations from whom representations were received is at Appendix 4

These included:

- a meeting of the Consultant Staff Committee;
- a meeting with union representatives;
- a meeting of staff organised by union representatives;
- four meetings for all grades of nursing staff arranged by the Director of Nursing;
- a meeting for therapists arranged by the physiotherapy representative on behalf of all therapists;
- a meeting for theatre staff; and
- a meeting with radiographers.

28. I held several meetings with the current Chairman, Chief Executive and Medical Director. This was largely to discuss the administrative arrangements for the Trust and its staff to engage with the Inquiry, but I also received relevant information and views, all of which were entirely consistent with the oral evidence they subsequently gave.

29. I visited the hospital on a number of occasions, once being given a tour of almost the entire premises by the Chief Executive, and on other occasions visiting particular parts of it unannounced, accompanied only by the Secretary to the Inquiry. On such occasions I took the opportunity to talk informally to members of staff I encountered.

30. As already indicated I met a number of members of staff, past and present, entirely privately but accompanied by the Secretary, where the individual wished to give information or offer views to the Inquiry but was only prepared to do so in this way. Some of those seen in this way subsequently accepted an invitation to give evidence at oral hearings.

31. I have had a number of informal meetings and other contact with members and representatives of the local community. These included members of Staffordshire County Council, Stafford Borough Council and the four Members of Parliament already mentioned.

32. In the early stages of the Inquiry I met representatives of a number of public bodies with a view to enlisting their assistance in the provision of material for it, and to gain an understanding of the environment in which the Trust had been operating. The bodies included the strategic health authority, the primary care trust, the Care Quality Commission and Monitor. In each case I met the Chair and Chief Executive. I also met David Flory CBE, Director General of NHS Finance, Performance and Operations, Dr David Colin-Thomé OBE, National Clinical Director for Primary Care and Medical Adviser for the Commissioning and System Management Directorate, and Professor Sir Bruce Keogh, NHS Medical Director,

all from the Department of Health. I spoke to Profesor Sir George Alberti, former National Clinical Director for Emergency Access. I spoke to representatives of local government: Matthew Ellis, Lead Cabinet Member for Adult Care and Wellbeing at Staffordshire County Council; Philip Jones, chairman of the Stafford Borough Council Health Scrutiny Committee; and the Coroner for Staffordshire (South District), Andrew Haigh.

33. I met Dr Laker and visited the independent case note review offices on several occasions to be briefed on the review process and progress.

34. I met the Parliamentary and Health Service Ombudsman to be briefed on the current complaints system.

35. In total, the Inquiry has been in contact with some 966 members of the public wishing to provide information about their experience of the care provided by the Trust to themselves or a relative. Of these, 89 were associated with Cure the NHS. Many had made no previous contact with their MP or any regulatory organisation, and in effect were giving an account of their experience for the first time. Of those who were in contact with the Inquiry, approximately 72% expressed concerns and 28% expressed positive views. Of those with concerns and complaints, some also offered positive views about other aspects of the care they received. Not all of those contacting the Inquiry wanted to describe experiences occurring within the time period of the terms of reference. An analysis of the nature of the concerns raised in letters and other written statements sent to me can be found at *Appendix 5*.

36. The Inquiry was not so fortunate in contacts by staff: 82 current and former members of staff contacted the Inquiry. Of these, 33% were nurses and 27% were doctors.

Choice of witnesses for oral hearings

37. It was not practical – and would not have been helpful – to hear oral evidence in relation to all the cases and complaints arising from events between 2005 and March 2009. The written material was examined and individuals were identified whose cases appeared to be representative or illustrative of a theme that had emerged, or which appeared to require clarification or resolution of significant disputed facts. In the case of staff, in addition to those who approached the Inquiry with information, I considered which other members of staff, including management, it was appropriate to invite to a hearing wether or not they had volunteered material to the Inquiry.

38. As already mentioned all staff and managerial witnesses I wanted to attend an oral hearing did so with one exception. That exception was Mr Yeates, the former Chief Executive. I received medical evidence, and independent advice from a medical adviser instructed on behalf of the Inquiry that satisfied me that unfortunately Mr Yeates was not fit to attend a hearing or to participate personally in the process in any other way. I was further satisfied that there was no likelihood of his recovering within the time scale of the Inquiry. Mr Yeates' absence was remedied in part, but only in part, by his solicitor making available to the Inquiry various documentary materials including a response prepared by Mr Yeates at the time of his departure from the Trust.

39. The information provided by those not selected as witnesses for the oral hearings has been taken into account. Every experience described by a patient, family member or member of staff proved has been valuable. Volume 2 of this report provides a synopsis of the evidence provided by each individual who wrote to the Inquiry with their experiences during the period under review. It is important to register and acknowledge the experiences that each of the contributors has had – as individuals and not as statistics: there is much to be learned from them.

The conduct of oral hearings

40. Between 2 November and 22 December 2009 113 witnesses attended oral hearings, principally as individuals but on occasions in small groups. Thus members of the same family were often seen together, and a group of former non-executive directors was also seen in this way. Witnesses were able to be accompanied by a relative, friend or advisers, including a legal representative. Where it appeared to me that such companions were likely to also be able to assist the Inquiry, they were invited to contribute. If present, legal advisers were invited to make a statement or ask questions of their client after questioning by Counsel to the Inquiry. In advance of their attendance, witnesses were sent any appropriate documentation which it was felt might assist them in giving their evidence or about which it was intended to question them. For example, those who had been interviewed by the independent case note review or the HCC were sent the notes of those interviews where these were available.

41. The evidence obtained at oral hearings was transcribed and a copy of the transcript was sent to the witness, who was offered an opportunity to amend or add to what had been said. Where this occurred I have proceeded on the basis of the amended version. Summaries of the proceedings were placed on the Inquiry website.

General approach of the Inquiry

42. It was not the purpose of this Inquiry to re-investigate the findings of the HCC's report, although some of the same ground has had to be travelled. In view of the fact that the Trust Board at its meeting on 29 April 2009 accepted those findings in full, it would not have been fruitful to do more than that. However, it was clear that there was a need to obtain and record the experiences and views of those most affected by what had been found to have gone wrong. Necessarily, therefore, this Inquiry has to some extent been led to look at areas about which those contacting the Inquiry have expressed the most concern, and the issues arising from those concerns. The result has been that I believe we have looked at areas which, while perhaps covered in the HCC's report, now need to be looked at in a different – and in some cases even more critical – light. For example, the almost overwhelming number of complaints I have received about the lack of basic nursing care led me to focus on this area. Therefore this report is not intended to include a detailed examination of the performance of every activity of the Trust, and indeed such an investigation would not have been possible in the timescale set for me. However, it is quite clear that the deficiencies which are identified indicate systemic failings which could affect areas other than those which have been the focus of the Inquiry. Part of what will be considered is what further inquiry is required.

43. The purpose of this Inquiry is to identify lessons to be learned and areas where further action is required, rather than to be a forum in which individuals are brought to account. Some of those approaching the Inquiry have made it very clear that they consider that there ought to be an inquiry which does bring individuals to account. In the course of this report I do not hesitate to make criticism of what was done where this appears to me to be appropriate. In many cases the deficiencies are probably not the fault of any one individual but result from collective failures. It would be very unfair in such circumstances to hold up one individual as having been responsible. Further, an inquiry of this nature is an unsatisfactory and unfair forum in which to determine the personal fault of individuals. Inevitably, issues and concerns have only been identified as the Inquiry has progressed, individuals are not represented or present throughout the proceedings, and it would not have been possible to provide those potentially to be held responsible with a fair opportunity to answer allegations against them. Had the Inquiry been set up to do this, the objective of identifying lessons to be learned would in my view have be prejudiced, and the procedure would have been protracted. Inevitably, some would have adopted a defensive attitude and been deterred from assisting the Inquiry in an open and candid fashion, leading to a reduction in the amount of useful information obtained. This does not mean that I have avoided looking at the processes of accountability, and indeed I will have a lot to say about these. Further, these considerations have not prevented me from making criticisms which potentially implicate individuals, and it will be

for others to decide whether further action is required in that regard. However, it is important to bear in mind that any such personal attribution of blame is a step which should only take place after those individuals have had a fair opportunity to answer any charges made against them.

Identification of individuals

44. All witnesses who attended oral hearings were informed about the Inquiry's processes. The names and personal details of witnesses who provided evidence have not been included to protect confidentiality. I have included the names of former and current directors of the Trust as by virtue of their positions they are accountable for the Trust's performance.

The report

45. The reader will be helped in following this report by first reading the HCC report[10]. As its findings are largely assumed where not explicitly referred to.

46. I felt it was important to reflect in the report the evidence I have heard and have therefore quoted extensively from what I was told. The Inquiry was principally set up to hear the voice of the patients, their families, and hospital staff, and it is only right that where possible the issues they raised are put in their words. Necessarily only selected extracts are quoted but those I have chosen in my view fairly represent the totality of the evidence received.

47. In previous reports it is not always possible to observe what those responsible for the management of the Trust have had to say in response to the issues raised and the criticisms made. I have sought to reflect fairly their views where these have been made known to the Inquiry, even where I have not agreed with them.

48. My views and conclusions are often to be found at the end of each section and in the final chapter, but inevitably they appear elsewhere as well.

49. In accordance with the basis on which witnesses were invited to attend the Inquiry patients and their families who have offered evidence and other information have not been named in order to protect their privacy. Staff members have also not been identified by name for the same reason. I decided that it was right that directors, both executive and non-executive should be identified in part because they are public accountable for the performance of the Trust and in part because it is inevitable that they would be identifiable by an examination of the role of the Board in any event.

[10] Healthcare Commission (March 2009) *Investigation into Mid Staffordshire NHS Foundation Trust*

50. The structure of the report is to start with a consideration of the patient experience before moving on to a consideration of the culture of the organisation and the experiences recounted by staff. I then consider various episodes about the management of which concern has been expressed. I then look at the Board and both its collective role and those of certain individual directors. This followed by an examination of mortality statistics before setting out my general conclusions and recommendations. Inevitably there will be some who feel that a concern of particular importance to them has been omitted. A hospital is a highly complex multi-faceted operation and an inquiry of this length and scope could not possibly look into every nook and cranny of it. Therefore this report does not and could not examine in detail each and every matter of concern which has been raised, but will focus on some issues which in my opinion are sufficient to reflect the problems the Trust faced and to inform an explanation of what went wrong and the lessons to be learnt.

Acknowledgements

51. To organise and support to a conclusion in the short time span required of us an inquiry which has been required to obtain and process the amount of material I have received is an immense undertaking. It would not have been possible without the unbelievably dedicated and hard working inquiry team under the leadership of the Secretary, William Vineall, and I am deeply grateful for all that they have done. This report would not have been possible without it.

52. I am also grateful to Counsel to the Inquiry and the specialist advisers for their constant and invaluable assistance and advice throughout the Inquiry process.

53. I have been significantly helped by the legal representatives of Cure the NHS their preparation of contribution of evidence and other material.

54. Finally and most importantly I would like to acknowledge with gratitude all those who have given evidence and other information to the Inquiry, and particularly those patients, and patients' families who have had to rehearse memories of such harrowing experiences.

PATIENT STORY

I heard from the daughter of an 86-year-old woman who was referred to Stafford Hospital by her GP in September 2007 complaining of recurring vomiting.

Her daughter told me that when she arrived at the hospital, her mother was alert and orientated and was able to see and comprehend what was going on around her. She was taken through to the emergency assessment unit (EAU). Her daughter's initial view of EAU was that the staff were caring but they were were struggling to provide care to the patients. Her major concern then was the number of junior doctors who came in and out of EAU, which confused her mother who was hard of hearing. She had to talk through her mother's symptoms a number of times and felt there was a lack of co-ordination between the nursing and clinical care.

Her mother remained in EAU for three days before being taken, by a porter, to Ward 10. This was a mistake as her mother was due to move to Ward 11. On Ward 10 she was left unattended for some time with another patient before a healthcare assistant arrived. Without saying anything, the healthcare assistant placed a tray of food on the table in front of the other patient, who was immobile and unable to reach the tray, and left again. She returned approximately 15 minutes later and collected the tray of untouched food.

Later that evening her mother was moved to Ward 11. The patient's daughter described Ward 11 as *"utter chaos"*. She said the chaos intensified at night when patients wandered around and approached other patients. Buzzers were constantly going off and it was extremely difficult to locate staff. She went on to describe weekends as *"absolute madness"* when there were even fewer nursing staff available and no doctor on the ward.

Shortly after her admission to Ward 11 it was decided that her mother needed a gastroscopy, which she was unhappy about as it had previously been deemed unnecessary. Her mother required oxygen, but there was none available during her move from the ward to where the procedure was to take place. The porter said he was in a hurry and so her mother agreed to be moved without oxygen.

Following the procedure there was a delay in bringing her mother back to the ward while nursing staff disputed whose responsibility it was to collect her. On her return to the ward the patient was not re-connected to oxygen. She collapsed in a chair and her family struggled to find anyone to help. A doctor was finally found and several minutes later asked that the patient's daughter sign a Do Not Resuscitate (DNR) form and *"He said: listen... the prognosis is very poor. He said:... her stomach has pushed up...she is going to die over the weekend and it is going to be a very painful death because what will happen is it can happen at any moment, any second now, it can turn, it can twist and she will die."*

After this shocking incident, the family agreed that they would never again leave the patient alone at Stafford Hospital.

Over the next few weeks, her condition improved and she was able to walk around and use the bathroom, and had a date to be discharged from hospital. During these weeks, her daughter told me there was no help with feeding. She said that if she had not been there to help, other patients would have suffered and would have gone without food.

One evening, when the patient was with her granddaughter, she needed help getting back into bed. A healthcare assistant attempted to lift the patient on her own and dropped her; she fell back into the bed, hitting her back on the bed frame, and fell unconscious. Despite her granddaughter's requests after the incident, the patient was not subsequently checked by any member of staff.

... from that moment on, she was just never the same again. I didn't recognise her. She just was a different person. She just clung to me and...she just couldn't get her breath, she couldn't breathe, I have never seen her like this before – on the Sunday. And the staff – they said: oh, it is a panic attack, it looks like it is a panic attack.

It was not until two days after the incident that the patient was assessed by a doctor. The doctor demonstrated little concern or interest and, despite her mother's weight having ballooned and her condition having changed significantly, he did not appear to recognise or respond to these changes.

The patient's daughter became increasingly concerned with her mother's deterioration, and on raising her concerns with a nurse she was given a medical book to look through to see if she could identify her mother's symptoms. She said that she saw immediately that her mother's symptoms were indicative of heart failure. She alerted a student nurse on duty to this, who said that she would refer her mother to a specialist. It took four days for her mother to be seen by a respiratory consultant who assessed her and said that the issue was with her heart.

Several days later, the family were told that the patient needed a blood transfusion. Given the risks involved, the patient's daughter was extremely apprehensive about her mother undergoing a transfusion. She was assured that the blood would be given very slowly and the drug frusemide would be given, which would eliminate the majority of the risks.

Having waited several days for the transfusion to take place, the patient's daughter decided to go home for several hours and she planned to return at 10pm. However, shortly after 9pm she received a call to inform her that her mother was being given the transfusion. She recalled *"racing back"* to the hospital but by the time she got there, the sister had finished administering the blood. She enquired as to why it had been undertaken so quickly and the sister responded by saying, *"...don't moan...because I have had no break today."*

The patient's daughter looked at her mother's drug chart and realised that the extra frusemide had not been given. She was told by the night nurse that her mother was not written up to receive the drug, despite it being normal process to administer frusemide during a transfusion. The patient's daughter asked if she could get the doctor to prescribe it and she responded by placing her hands on her hips and saying that she was in charge of the ward and would therefore decide when a doctor was called. Her mother did not receive the standard dose of frusemide until 4am the following day and there is nothing in the notes to indicate that her mother ever received the agreed additional dose. She recalled, *"I went home in tears; I had seen enough. The confused man in the next bay was once again being shouted at and told to stay in bed. I was exhausted, since my mother's fall she had not slept one night."*

She was called by her own daughter to the hospital the next day because her mother was very poorly and tragically she passed away that day

When asked to describe the nursing culture on Ward 11, she said: *"They were bullies. They bullied...the other staff and they bullied the patients. There was no word for it. ... particularly during the two weeks that Mum was dying, effectively, they were calling out for the toilet and they would just walk by them."*

Section A
The patient experience

Introduction

1. The terms of reference require me first and foremost to listen to and report on the accounts by the patients and those who are close to them of the care experienced at the hands of the Trust. It was considered by the Secretary of State, rightly in my view, that the perspective of those most affected by what has happened had not been taken sufficiently into account in the previous reports. It would be quite wrong for inadequate recognition to be given to the suffering of those who have had to witness and experience a lack of care and mistreatment which have no place in any civilised and well run health service, and their experiences should be used to inform what needs to be done in the future. The principal, if not the sole, purpose of having a National Health Service is the promotion and protection of the health and welfare of those who seek its help. Where those who do so are systematically mistreated and left without care in such numbers, and with the frequency that has been shown by the evidence presented to me, their voice must be listened to with particular care – all the more so when those charged with the responsibility of ensuring an appropriate standard of care have apparently failed to detect or react to bad standards at virtually all levels of the system.

2. There is an additional and equally important reason why I should report in some detail on the experiences of those who have sought the help of the Trust and its staff. As we will see, a constant refrain I have heard from staff members is that while they accept that there have been instances of bad care, this has not been the case in all areas of the Trust, and that in effect those who have provided a good standard of care have been unfairly tarred with lapses elsewhere in the organisation. I was told that these incidents had been taken out of context. There have also been a number of staff members who have suggested that at least some of the claims made about bad care have been exaggerated. Thus a ward manager told me:

   I think some of the problems were exaggerated. We accept that some of the problems has happened and I think it is very difficult to explain and even to justify why it happened. I know for a fact that there were pockets of very good care being carried out, they are not going to report on that. You look at it and you think: gosh, all the patients in wards 10, 11 and 12 were starved, all patients were drinking out of vases.

3. As it happened I did not hear any direct evidence about any incident involving vases. Such an incident is not directly reported in the Healthcare Commission (HCC) report. There was, however, much reference to patients drinking out of vases in the press.[11] I am therefore unable to express a conclusion about whether

[11] See for example 'Bosses to blame for "Third World" hospital Mid Staffordshire NHS Foundation Trust' (*The Times* 18 March 2009); 'Brown apologises for unacceptable failings at Stafford "Third World" hospital' (*Daily Mail* 19 March 2009)

this occurred or not. However, any uncertainty about this particular case should not be allowed to detract from the range of evidence from patients and their families describing unacceptable care.

4. The Inquiry made contact with 966 patients and families giving accounts about care received. In some cases the accounts concerned the care of more than one person and also included a description of what they witnessed happening to others around them. While some of the stories I received concerned events outside the dates within the terms of reference, most did fall within that period. As will be seen, the complaints made concern care given in many parts of the hospital (and occasionally at Cannock Chase Hospital), although it was predominantly the accident and emergency department (A&E), the emergency assessment unit (EAU) and Wards 7, 8, 10, 11 and 12. It was striking how many accounts I received related to basic elements of care and the quality of the patient experience, as opposed to concerns about clinical errors leading to death or injury. That is not to downplay the significance of the evidence I received on such matters. but to emphasise the importance in the minds of those who receive hospital services of the general quality of care they are offered.

5. In assessing the evidence I have received, both written and oral, I have borne in mind that this has been an inquisitorial process and not a trial at which disputed points of detailed fact have been fully identified and explored by cross-examination. In very few cases has it been possible to hear from the members of staff who may have been responsible for providing the care in any particular case and to question them about it. Indeed, it might have been unfair to do so given the passage of time and the often inadequate state of the medical records available to refresh memories about individual cases. However, the evidence of multiple and wide-ranging incidents of bad care as described by patients and their families has been such that it is impossible to do other than accept that, in the vast majority of cases, events have occurred as they have described.

6. Without exception I was impressed by the care and candour displayed by the witnesses who came to see me. They were not people prone to exaggeration and took great care to present a balanced account of what had happened. Thus many were at pains to acknowledge and tell me about good care they had received in some parts of the hospital or from particular members of staff. Others were careful to ensure that I did not receive an exaggerated impression of the frequency with which events of which they complained occurred. For example, one witness, who had presented a witness statement in which his wife had been described as having been *"continually left in a soiled bed",* was anxious to correct this at the outset of his oral evidence, changing this to *"occasionally left in a soiled bed"*. All witnesses, even though they were often describing highly distressing events such as the suffering of a loved one close to death, did so with great dignity, and conveyed a sense of incredulity that such things could happen in a hospital in this country. Many wanted to support what they obviously regarded

as their hospital. Finally, the accounts given to me provided powerful confirmation of one another. Most of the complaints had been made in writing before the publication of the HCC report and the surrounding publicity. Most witnesses had no contact with one another before this Inquiry. Yet I heard time and time again similar stories of the type of problems encountered. In the vast majority of cases in which witnesses had made complaints to the Trust about bad care, the substance of their complaint had been accepted by the Trust. Therefore, in spite of the limitations of this form of inquiry highlighted above, I am fully satisfied that the evidence given by patients and their families to me represents a fair account of the standards of care being provided at the times described.

7. The experience of listening to so many accounts of bad care, denial of dignity and unnecessary suffering made an impact of an entirely different order to that made by reviewing written accounts. It is fair to say that all members of the Inquiry team and advisers who were able to participate in these hearings were deeply affected by what we heard. While it is difficult, if not impossible, to convey this impact by the written word, in my view it is important that staff employed by the Trust, as well as the general public, have access to the accounts I have received, both written and oral, so that they can make their own assessment and be motivated by this material to inform the promotion of good standards of care in the future. This may also help them, individually and collectively, to acknowledge and accept that care given in the past fell far below what was acceptable. For this reason I have included in Volume 2 of this report a summary of each case about which I received evidence. I hope that this will also offer some public acknowledgement of the important contribution made by everyone who has written to the Inquiry to share their experiences, and allow their voice to be heard by all those who have responsibility for the delivery of care in this and other hospitals.

8. In this section I shall identify the themes that have emerged from this evidence and give examples of the accounts which support those themes. Many other examples can be found in the more detailed summaries in Volume 2. I have taken as categories in part some of the benchmarks recommended in *Essence of Care*,[12] first published by the Department of Health in 2001, revised in 2003, with a further revision currently under consultation.[13]

    - Continence and bladder and bowel care
    - Safety
    - Personal and oral hygiene
    - Nutrition and hydration
    - Pressure area care

[12] DH (April 2003) – The Essence of Care: patient-focused benchmarking for health care practitioners
[13] The Essence of Care benchmarks are set out in Appendix 6

- Cleanliness and infection control
- Privacy and dignity
- Record keeping
- Diagnosis and treatment
- Communication
- Discharge management

9. In some sections where it has appeared to me to be helpful, I have made specific reference to the Essence of Care benchmarks. I note that the Trust itself sought to implement these principles as part of its response to the 2002 Commission for Health Improvement report through the appointment of a project manager.

CHAPTER 1

Continence and bladder and bowel care

10. Many of the patients about whom I have heard had continence problems, either due to pre-existing infirmity or hospital acquired infections. It hardly needs stating that incontinence requires conscientious attention and nursing care. Incidents of soiling can be avoided by prompt attention to calls for assistance, either with provision of bedpans or commodes, or access to the toilets. Where such assistance fails to prevent soiling of clothes or bedding, replacements need to be provided and the patient cleaned up as soon as possible. While any episode of incontinence will be distressing to those affected, the suffering will be compounded if help is not swiftly available and if unsympathetic attitudes are displayed. It cannot be pretended that continence care is a pleasant aspect of nursing, but it is an essential part. Deficiencies in standards of care in this area not only cause suffering but can be detrimental to patients' health; lapses will always prejudice patients' dignity.

11. I have received evidence suggestive of a widespread failure to observe adequate standards of continence care. In some cases the complaints have been associated with cases of *Clostridium difficile* (*C. difficile*), and most concern elderly or confused patients. However, the evidence suggests that the problem has occurred over much of the period with which I am concerned.

12. Of the 33 cases that were heard at the oral hearings, 22 had significant concerns. The principal themes emerging are as follows:

    - Those requiring help to use a bedpan or to get to and from a commode or the toilet were not responded to when help was requested and were not checked regularly or at all.
    - Such omissions frequently led to patients having to soil their sheets, in which they were then left for an unacceptable time.
    - Some patients were left on commodes or in the toilet for far too long.
    - The attitude of at least some members of staff to these experiences gave the appearance of being unsympathetic and uncaring.

Requests for assistance

13. The effect of patients' requests for toileting assistance is exemplified by the following extracts from the evidence I heard.

14. The daughter of a patient in Ward 11 in September 2007 told me:

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

In Mum's bay the woman in the next bed, she would sound the buzzer and it would just go off and off and off and then the same – it was the same thing, she would just call out for the nurse. When the nurse did come, she would be put on to the commode and it was obviously too late. The nurse would put her back into the bed, you could hear her – she would wait on the commode for half an hour and very often she would just try to make it herself and just go smack on to the floor. So you would have to go searching – if you couldn't do it yourself, you would have to go searching, and I mean searching, for the staff. Very often you would just give up. I would just have to give up.

15. The daughter of another patient on Ward 10 in February 2008 told me:

Ward 10 was an open ward, so my Mum was in a bed in a row, there was a row each side, and she was quite a long way from the toilet and she still was not in control of her bowels and her bladder. Sometimes when I visited her she would be saying: I need to go, I need to go. As I said, two people to get her there, or it took a wheelchair or it took a commode on wheels. Sometimes I could not find a nurse to help, so I would take her, which probably wasn't a good thing, to the toilet, just her and me and her zimmer frame, and that was quite a struggle because it was all the way down the ward and along the corridor and into the loo. And sometimes she would be really busting to go and she would go. So I would take her back to the bed after I had wiped her and so on, and say to the nurse: she has just been to the toilet, do you need to write that down; if I could see one. They would go: oh, yes, fine. Nobody wrote it down, so I used to write it down, as part of my record of what went in and what came out. So it was difficult to find somebody when she wanted the loo. Seeing me take my Mum to the loo, other old ladies on the ward would say: I need to go. So I would try and find a nurse to help them and the nurse would say: all right, in a minute. And then they would be gone and it would be quite a long time.

16. The wife of a patient on Ward 10 in July 2007 told me:

There was a care assistant on the ward the one particular day, and there was like four beds where my husband was and four beds the other side. And I said to her, his buzzer was going to go to the toilet and I said: excuse me, can you help my husband to the toilet? She said: no, I can't help him. I said: well, why not? She says: I am looking after the four beds down there. Well, they were all lying down. I said: well, they are all sleeping. In the end she said: go on then, I will help him; but she took him to the toilet but she never waited for him to come back, and when he came out, I couldn't believe it because he had to call me over to hold his pyjama trousers up so he could wash his hands, he had lost that much weight.

17. The daughter of a patient on Ward 7 in July 2007 heard her father tell of the difficulty in getting help:

He was very distressed, saying he had rang the bell during the night for the nurse to come, he needed help to go to the toilet because he was told not to get out of bed without – unless there was help there. He had rang the buzzer. He must have waited nearly an hour. The same thing happened to the gentleman in the opposite bed who was older than my father on a couple of occasions, and I think he ended up soiling the bed linen, and he was very, very distressed. Obviously I overheard and I said I was going to complain. He got very, very agitated and distressed saying: don't say anything, don't say anything, they will take it out on me.

18. Many families also raised this concern in their letters to me. One daughter wrote to tell me about her mother who was admitted to A&E in October 2008. Her mother was taken to Stafford Hospital and put in a side room. Three hours elapsed before she was allowed to see her mother. Her mother immediately asked for a commode and told her daughter she had been asking for one for an hour. The staff in A&E said they only had one on the ward and she would have to wait. When it finally arrived, no one helped to get her mother on or off the bed. She recalled they had to *"struggle and try and shuffle her to the end of the bed to move her and I had to take all her weight myself to support her on and off. This happened about 10 times. When we asked for hep they said she would have to wait."*

Patients left in soiled sheets

19. The accounts of patients left for unacceptable lengths of time in soiled bedding included those whose calls for help to go to the toilet had not been answered and those whose incontinence was caused by *C. difficile* or other illnesses. The distress and suffering caused by this is almost unimaginable when imposed on often frail and elderly patients fully aware of how they were being robbed of their dignity.

20. The sister-in-law of an elderly retired agronomist described the effect of this form of neglect on him when he was on Ward 7 in January 2006:

... the nurses there weren't unkind to him, but they were overworked. We often felt that if we asked them if they would clean him up,... it would be hours before they came back to clean him up, and in that time he was just lying in a dirty bed with dirty nightwear on, and he didn't want me to go in the room, even. He would say: don't come near me, don't come near me, I smell; and he was a very fastidious man and he really was left lying in his own excrement.

21. A 96-year-old patient suffering from dementia and admitted to the EAU via A&E in June 2006 was, according to her daughter-in-law, left in a shocking state after she had soiled herself:

We got there about 10 o'clock and I could not believe my eyes. The door was wide open. There were people walking past. Mum was in bed with the cot sides up and she hadn't got a stitch of clothing on. I mean, she would have been horrified. She was completely naked and if I said covered in faeces, she was. It was everywhere. It was in her hair, her eyes, her nails, her hands and on all the cot side, so she had obviously been trying to lift her herself up or move about, because the bed was covered and it was literally everywhere and it was dried. It would have been there a long time, it wasn't new.

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 have 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 would have 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?

22. Another patient of whom I was told was on Ward 2 in August 2006 suffering from cancer. She was described to me as *"an incredible lady who had an absolute heart of gold and would have helped absolutely anybody"*. She contracted *C. difficile* and became incontinent. Her daughter told me of her experience of having to clean up her mother herself:

If you have ever smelt somebody who has C. difficile, it is a smell that never – it never goes; you can instantly identify the smell. She sat there, and she was a very proud lady, a very clean lady and she looked horrified. I said: Mum, don't panic, I will get somebody to help to clear you up as soon as I can. There was not a nurse around, there was not a doctor around. I looked for so long, it was a good half an hour, and there was nobody anywhere. So in the end, I got some rubber gloves and I started to clean my Mum myself. At that point one of the nurses said: your Mum is highly contagious and you should not be cleaning her. I said: where are you; I need some help here, I can't leave my Mum sitting in her own faeces in a ward with visitors and everybody watching her. At that point they came to actually help me but it was a good half an hour and I had almost cleaned my Mum up at that point.

23. I was told by the wife of a patient who had been on Ward 6 in July 2007 that he had been left in bed for prolonged periods after he had soiled his sheets. On one occasion when he was taken out of bed he was left in a chair for three hours and was too frightened to get back into bad for fear of spoiling it again. I describe more of her evidence on this point with reference to staff attitude below.

Patients left on commodes

24. The wife of one patient, who was in Ward 12 in October 2006 just one day before he died, told me how he was left on a commode for 55 minutes dressed only in a pyjama jacket as staff wanted a sample. When she spoke to a member of staff about this:

    All I got was that they were busy. I know they are busy but come on, it is disgraceful... I mean sitting on there like that is one thing, but when you were poorly like he was, it is just not good, is it really?

25. I was told by the daughter of a patient who was on Ward 2 between July and December 2006 about an occasion when she found her mother on a bedpan. Her mother told her she had been there for over an hour: it was evident she was in considerable pain:

    And as I walked in my Mum was on the bed, on a bed pan, and she was falling off and she was in agony. She had been left like that for over an hour. The nurses' button which, if you read in the notes, my Mum had said before, please don't put it out of reach, was left on top of a drip. I struggled to reach the nurses' button. My Mum was in absolute agony, I can hear her screams now, as I walked into the ward. I slammed the nurses' button, the emergency button. Nobody came and I ran out and said: please, somebody come and help my Mum. As we went back in with the nurse, they went: ooh, we'd forgotten about her. I said: can't you hear. And at that point she grabbed my hand and said: please don't

let me die in here... the nurse came that came in said: I am so sorry, we had forgotten about her; yes, she has been there for some considerable time...

26. A witness visiting and caring for another patient in Ward 11 in September 2007, already quoted above, described seeing the difficulties suffered by a nearby woman and the danger to which she was thereby exposed:

In Mum's bay the woman in the next bed, she would sound the buzzer and it would just go off and off and off and then the same – it was the same thing, she would just call out for the nurse. When the nurse did come, she would be put on to the commode and it was obviously too late. The nurse would put her back into the bed, you could hear her – she would wait on the commode for half an hour and very often she would just try to make it herself and just go smack on to the floor. So you would have to go searching – if you couldn't do it yourself, you would have to go searching, and I mean searching, for the staff. Very often you would just give up. I would just have to give up. There would just be no nurse on all of the bays. You couldn't find anybody. So I would have to come back and put a pillow underneath her or try to get her to scramble into the bed.

... But if the nurse put her into the bed, very often you would... her moan. She had been put back into a wet bed. So then she would press the buzzer again and then there was another 40-minute wait for the bed – for her to call the nurse back again and then the bed to be changed.

27. The accounts given earlier in this section suggest that staff were at best defensive and at worst uncaring about delays in attending to the continence needs of their patients. Even if such lapses in care became inevitable because of staff shortage, there can be no excuse for such attitudes.

Laundry services

28. A number of families appeared to believe that it was their responsibility to take home soiled bed clothes and nightwear for laundry. This occurred even in some cases where the sheets may have been soiled with infectious material. It was not suggested that families or others were ever actually told this by staff, but a mistaken assumption may have arisen from the way in which soiled sheets were dealt with once they had been taken off the bed.

29. For example I was told by the 90-year-old husband of an elderly demented patient about what he felt he had to do after his wife was admitted to Ward 7 in January 2008:

There was always a black bag in this cabinet at the side. I think that was for them to put the soiled nighties, or whatever it was in there. I didn't realise, until after a fortnight, that there was a laundry service. Me being me, think I have got to take Irene's nightwear back home to wash it and I did do for the first week. Not knowing – nobody said: you needn't take that, Mr ..., we will deal with that. Nobody said a thing.

30. The wife of a patient who stayed on Ward 12 on a number of occasions between August and September 2006 clearly believed it was her job to take soiled laundry home. On one occasion after he had soiled the bed:

This .... nurse that I had asked in the beginning, she had come back; whether she had come back to take John to the toilet, I don't know. She just stripped the bed, wrapped it all up and put it in a blue bag. I said: put that in your washer, it will disintegrate. So I washed the hospital sheets, and I took them back the next day and gave them back to the same girl.

31. It was also apparent that some families felt compelled to change soiled bed linen themselves as nursing staff did not appear to be available. The wife of a patient on Ward 10 in July and August 2007 told me she had to do this a number of times:

There was nobody around, actually. I couldn't find anybody to come and change the bed. So I went looking for sheets myself and found some on a trolley and took them off that.

Staff attitude

32. The daughter of one patient suggested to us that staff may have become *"blasé"* about the impact of incontinence on patients mental well being and morale. A daughter of an elderly patient who was on Ward 6 during an admission lasting from August 2006 to March 2006 told me how they had had to wait for a bedpan after ringing the buzzer for 20 minutes, after which her brother went for help:

He went down to where the desk was, and I think he said there were four of them sitting on the desk. We appreciate notes have to be passed on from one shift to another. I have been a shift worker, so we do appreciate that. But not to the detriment of the patient. My brother just said: excuse me, what happens when a patient rings a bell? They said that bell – that light up there lights up. He said: you mean that one that must have been lit for at least 20 minutes? They said, oh. And he says: my Mum badly needs the commode. They said: we will be

here in a minute, we are just finishing these notes. He said: no, my Mum needs one now. And he stood there and he waited, and then it was a tut and one of them got up and went with him.

33. On another occasion there was a delay in providing a commode and there was an accident. The patient's wife described the staff's attitude:

... he had an accident, faecal incontinence. It was after he had a biopsy, I do not know whether that was anything to do with it, probably not, that I was visiting and he pressed the button for a nurse because he said: I need to go to the toilet. So I said: can I help you? He said: I have not got the strength, it is coming, quick. And so I went to find a nurse and I helped myself to the commode and by which time it was too late and so I had to go and find a nurse and say: I am sorry, but we have had an accident. She said: couldn't you get to the toilet? So he said: I am sorry, no, I couldn't. But after that they came and cleared up.

34. The effect on patients can be very concerning, as illustrated by the account given to me by the wife of the patient on Ward 6 in July 2007 referred to above. Although she thought her husband to be a strong and vocal character, he was reduced to a state of fear by one particular nurse:

It got to the point that when he did get his bed changed, if he had messed in the bed, he was frightened to get into bed, because there was one particular nurse that was on night duty, and my husband was one that if he disagreed with anything, he would tell you straight. And [about] *this particular nurse, he said to us – he said: I hope she is not on night duty tonight. I said: why? He said: she is horrible to me. I said: why haven't you said anything. He said: I don't know. I said: well, next time you tell her. And I think it was either on the second or third night that he did actually tell her and say: what's the matter with you? And she says: oh, I've got a cob on. In other words, she was in a bad mood and she had been for three days. So she was taking it out on the patients. She got him up the one morning after he had rang the bell and he had actually messed himself, sat him in the chair at 5.00am and he was still there at 8.00pm. He hadn't been moved.*

Impact

35. These omissions have on occasion led to patients struggling to care for themselves, leading to injury and to all losing their dignity and suffering avoidable distress, often in the final days or hours of their lives. The impact of this on both patients and their loved ones is almost unimaginable.

36. The daughter of a patient who suffered double incontinence while in hospital put it graphically:

    My Mum felt ashamed. She felt 2 years old. She felt ashamed. She said: I have wet myself, I feel awful, how can I wet myself at this time?

37. The patient's son-in-law added:

    She felt like she could not face anybody in the ward again.

38. The wife of another patient told me:

    He was frightened. He got to the point that he was frightened to get back into bed. He was frightened to mess the bed, and that is why he never asked anybody to get him back in bed.

39. The daughter of an elderly patient who was on Ward 2 between July and December 2006, (already referred to above) described how her mother had developed sores on her legs as a result of being left in her urine and faeces. The impact on both of them over an extended period of time was frightful:

    Q: *What about beding? With this dreadful condition, was your mother routinely soiling her bedding?*
    A: *She was, and I would constantly go and look for nurses, and at one point the nurse said: be really careful if you move the bedclothes on your Mum. And I said: why is that? And they said: because her legs are red raw; she has been sat in beds, faeces and urine soaked sheets for so long, as I lifted the sheets, her legs were red raw. She would often soil herself, and some of the nurses and the auxiliary staff were actually, whilst I was there, were quite, I would say stroppy, almost. You need to let us know. I would say: she has been calling, but she can't get to the button. My mother would never soil herself. That goes so against the grain. She was such a proud, clean lady that she would never have wanted to do that, and she would not have wanted to make extra work for somebody else. That is not my Mum's nature, she would not have done that. But she was left so often in a soaked bed or a urine and faeces – and incredibly, if she ever did get support, if she ever got support onto a bedpan, she had – because the nurses told me it was not in their remit to cut patients' nails, she would have faeces under*

her nails, and I would say: please get me some soap and water, I will bring the scissors in, I will cut my Mum's nails, but please, she's just been onto a bedpan. They would then come in with a drink. Nobody has washed my Mum's hands. Surely this infection would go, would just follow all the way through, it would get worse, and at one point they had a basket at the end of the bed that they would put sheets into, and we would go in and they were covered in urine, and they were covered in faeces and the smell. And we would constantly drag this out and put it outside of the room and said: please, would you not leave this in my Mum's room because all of the germs are airborne and they are – as soon as we had gone, it would be put straight back in again.

40. Additionally, in cases where patients have died shortly after such incidents, their loved ones' memories of the patients have been indelibly tainted by these experiences.

Comments

41. Some of the descriptions I received of lack of continence care might have seemed barely credible if they had been isolated. This was not an issue where it was ever going to be possible to establish the truth by a forensic examination of the medical records of individual patients: these, even if carefully kept – and many were not – would not have been likely to reveal detail confirming or refuting the standard of continence care provided. As pointed out earlier, it would have been difficult to examine nursing staff about individual cases as they could not reasonably have been expected to remember them. However, I could not fail to be impressed by the number of witnesses who made a similar complaint of extensive neglect of this most basic of needs. Some witnesses may well have had difficulty in being precise about when these incidents occurred, but so many gave me the impression of continuous neglect that I am satisfied that what I have been told is true in all material respects. To those who argue that the effect cannot have been as bad as portrayed above, I simply ask the reader to consider whether any of the accounts quoted here indicate a justifiable standard of care, and whether any of them are consistent with a systematic provision of good care. I suggest that the answer has to be that such a level of care was conspicuously absent for these patients and their families.

42. Looking for what may have been the cause of these deficiencies, I have identified a number of possible causes:

    - In a small minority of cases it would appear that staff have exhibited an uncaring attitude. The nature of this will be examined in more detail later in the report.
    - More often, it would appear that there were inadequate staff on duty to deal with the challenge presented by a population of elderly, confused patients.

- It is possible that there has been a lack of training in continence care. Many problems can be avoided by careful management of patients known to suffer from this problem.
- At times these problems have been compounded by the problems of infection control, which resulted in many patients contracting *C. difficile* which in turn would have further stretched the nursing staff.
- It is difficult to believe that lapses on the scale I have been told about could have occurred if there had been an adequately implemented system of nursing and ward management.

CHAPTER 2
Safety

43. In the covering letter to his report on the *C. difficile* outbreak at Stoke Mandeville in 2006, Professor Sir Ian Kennedy stated:[14]

    we demonstrate again the need to place the safety of patients at the forefront of the agenda of healthcare. Safety cannot ever be allowed to play second fiddle to other objectives that may emerge from time to time. It is the first objective.

44. By *"again"*, Sir Ian was referring to the fact that he had occasion to enunciate the same message in his inquiry into children's deaths in Bristol.

45. This was swiftly followed by *Safety First: A report for patients, clinicians and healthcare managers*,[15] which noted that the National Audit Office had found that:

    The safety culture within NHS Trusts is improving. Most Trusts have established a clear and strong focus on patient safety, driven largely through implementing the clinical governance initiative and the development of more effective risk management systems.

46. Lord Darzi, in his interim report,[16] identified as one of the visions for the NHS the proposition that it should be safe:

    [The] *NHS must be as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.*

47. He made it clear that:

    Safety should be the first priority of every NHS organisation. People rightly expect to receive the safest possible care and to be confident that this will be the case.

[14] HCC (July 2006) *Investigation into outbreaks of* Clostridium difficile *at Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust*

[15] DH (December 2006) para 1.23

[16] Department of Health (October 2007) *Our NHS, Our Future – Next Stage Review Interim Report*, page 42

48. In his final report, he reiterated the fundamental importance of keeping patients safe:[17]

The first dimension of quality must be that we do no harm to patients. This means ensuring the environment is safe and clean, reducing avoidable harm such as excessive drug errors or rates of healthcare associated infections.

Continuously improving patient safety should be at the top of the healthcare agenda for the 21st century. The injunction to 'do no harm' is one of the defining principles of the clinical professions, and as my Interim Report made clear, safety must be paramount for the NHS. Public trust in the NHS is conditional on our ability to keep patients safe when they are in our care.

Safety is the responsibility of all staff, clinical and non-clinical.

49. While these documents considered a range of dangers and risks, and perhaps principally hospital acquired infections, the exposure of patients to the risk of falling was clearly included. Therefore it should have been obvious to any trust management between 2006 and 2009, if not before, that a high priority was to be accorded to patient safety in all its aspects. Understandably safety is a primary concern of hospital users, and I note that between 2004 and 2007 complaints about safety formed the largest group of second stage complaints considered by the HCC nationally.[18]

50. It is clear from the accounts of their experiences given to me by patients and their families that safety has not been the first priority of the Trust. The issues surrounding infection control are well documented in the HCC report.[19] The evidence I received from patients relevant to this is addressed in the sections below about toileting and hygiene. That report did not focus on the issue of patient accidents and injuries from falling, although it did refer to a complaint upheld in 2006 about Ward 11 involving falls.

51. The Inquiry received striking evidence from relatives of elderly patients about the incidence of falls. Some of these falls led to serious injury, many if not all took place unobserved by staff, and too many were not reported to concerned relatives for far too long, or only when they saw an injury for themselves. Recording of falls in the patients' records was of questionable accuracy, and incident reporting of some falls was poor. What follows is a consideration of just some of the cases of which I was told.

[17] Department of Health (June 2008) *High Quality Care for All – Next Stage Review Final Report*, page 44 paras 52, 54 and page 47

[18] HCC (February 2009) *Spotlight on Complaints*, pages 45–46. The report did not break down figures to show the proportion raising safety issues for 2007/8.

[19] HCC report pages 84–87

52. One of the most striking cases concerns a patient who suffered no less than three falls within five days, having been admitted via A&E because of a fall at home. She was 90 years old, and independent before admission, but died shortly after the third fall. There is no evidence that any preventative measures were taken on Ward 10 in spite of the fall in EAU. None of the falls were observed by staff. There is no evidence of any effective planning in Ward 10 to address the now known risk. As the patient's son commented:

... the last incident report that was completed in EAU, the nurses stated quite clearly that...: "This patient is likely to fall again..." She was passed to another ward. Whether the communications between the two wards is non-existent or is lacking in some way, but obviously the fact that they said that my mother was a high risk, was likely to fall again, and then to put her sitting in a chair, to my way of thinking, is ludicrous.

53. The patient's family were not informed that she had fallen until they had noticed that she was confused and had been injured on their next visit.

54. The third and final fall had disastrous consequences. I consider it instructive to record here what the patient's son told me happened when he arrived at the hospital, having been called by hospital staff to say there had been another fall:

When I got up to ward 10 I said: you have called me to see my mother. And they said: you can't go in. I said: what do you mean; you have called me and I am here, I want to go in to see my mother. You can't go in. And they took me into a room and there was doctors and nurses talking to me. I was frightened because I couldn't understand. They had phoned me to go up as soon as I possibly could, and as soon as I got there, I was being withheld from going to see my mother. So it frightened me, I thought obviously there is something wrong. They were so busy trying to keep me away from the actual ward that my sister arrived unnoticed to them and she walked straight into the ward. Then, she came in to see me and she said: have you seen Mum? And I said: no. My sister was crying. There was a doctor there [... and he] *said: you had better let him go and see his mother.*

I walked into Ward 10. My mother was lying on grey marleytiled floor, lying full stretch out on the grey marleytiled floor. Some effort had been made to remove all the blood. It was smeared all over the floor. You could not see a hair on her head. It was completely swathed in bandages. And there was a lady doctor holding my mother's head in her hands like that, and I said: oh Mum, what have they done to you? And I looked at this doctor holding my mother's head and I said: this is my mother. As cold and as calculated as anything, her retort as fast as anything was: I have got a mother too. There was no compassion in that woman whatsoever. My sister then said: look, the side of the beds are down

and the bed is in a pristine condition. And she said: that is because your mother wasn't in her bed, she was in the chair. So that means that when I saw my mother at 3 o'clock until her fall at 10.30, she had been left sitting in a chair. This is a lady as far as my sister and I are concerned is completely immobile. We don't know that my Mum can walk, yet they have left her sitting in a chair on her own.

55. The son summarised the terrible experience they all had:

Dr [....] *is the only one I can say that showed that night any compassion to us as a family. Dr* [....] *turned to me and said: "We have let you down." Those were his very words. "We have let you down." And believe me, Stafford Hospital did let us down. They let my mother down, they let her die and they let us down as a family with the information that they failed to give us.*

56. As the son quite reasonably put it:

We entrusted my mother into this hospital to be cared for, to be looked after. But when you think about it, logically, 31st October she was admitted, she died on 6th November and within those few days this hospital let her fall over three times and she had been admitted because she was unstable on her feet. Well, as we thought, immobile. We don't know she was walking about in the wards until we received incident reports and as I said we were never ever made aware by any of the nursing staff that there was a problem.

57. Despite falling in EAU and the risk of falling noted in the records, there is no evidence of a falls risk assessment being undertaken for some days later.

58. The incident reporting of these falls was also deficient. There was no report at all in relation to one of them. The Trust accepted in response to a complaint that such incident reports as were located were inaccurate. The conclusion stated in the letter was that:

There is no accurate completed incident form relating to your mother's fall on EAU on 2 November 2008. The three completed incident forms contain misleading and inaccurate information. A review of the nursing and medical records has identified the recording of the three falls which your mother sustained. Unfortunately the entries for the first fall do not give an accurate time of the fall, which in turn are misleading, because the entries span over two consecutive dates.

59. This episode indicates serious lapses in the Trust's duty to care for the safety of an obviously vulnerable patient. This admission post-dates all the reports I have referred to above emphasising the priority to be accorded to safety. Vulnerable and elderly patients are entitled to expect that the level of observation and support will be such that repeated and dangerous falls are avoided. Tragically this was not provided in this case.

60. Some two months later another patient of a similar age was able to fall out of bed following admission to Ward 11 in January 2009 because he had not been provided with cot sides. Again no contact was made with the family about this until the fall was reported to the patient's daughter by a fellow patient:

There was a person over in the corner who was there, I can't remember why he was there but he was perfectly – he was a younger person... He said to me... by the way, your father fell out of bed. Dad was in a bed that had no sides on it and he was very – he had problems, he was very bent... Apparently they had to push his bed up against the wall. When I got home I didn't think about it until afterward. I thought why didn't they provide him a bed with sides on it so he wouldn't fall out of bed. Apparently he had fallen out and they couldn't lift him. They had quite a struggle getting him up again.

61. A confused 90-year-old woman, suffering from diabetes, was admitted to Ward 10 in May 2008 for treatment in respect of a bladder tumour. She had a history of falling at home, but although she was assessed as having an increased risk of falling no precautions were taken to protect her from this. In the course of her stay on this ward, three falls are recorded. After the first fall relatives were horrified at not having been told of what had happened and only discovering this on seeing her bruising when they next visited. Her son and daughter-in-law told me:

When did we discover her? When we walked into to visit her and we were greeted with her sitting there and looking like that and we were horrified...

62. Although there was a note in the patient's records for 8 June of a request that the family be informed every time there was a fall, they told me this had not happened. They showed me a photograph of the patient's bruising which was extensive and would have been distressing to the patient, and to family members who saw it. There is a record, dated 20 June 2008, in this patient's medical records stating:

Patient has numerous skin tears from falls on the ward... Patient at high risk of falls, has been given a zimmer frame to mobilise, however, has fallen several times on the ward with it, cutting her face.

63. It is predictable that an elderly, confused patient who is mobile will fall if left unsupervised and out of bed. It is difficult to discern from the evidence any protective steps being taken to prevent this occurring in this patient's case. The family's comments on this state of affairs are understandable and reasonable:

We were told that her dementia had set in by this time, and whatever instructions she was given, she would not retain. Therefore although she was told not to get out of her chair, she ignored it; although she was told to press the buzzer, she didn't do that. And we do not know whether she tripped over the bedside table or tried to get to her frame but she obviously fell flat....

... I think it is absolutely atrocious that on a ward that deals with elderly people that there is nobody, you know, keeping watch to see the patients who are prone to this – to falls. I mean, there just weren't the staff around and [my mother-in-law] *wasn't the only one who was unsteady on her feet. It is diabolical really to think that they can let it happen. You know, maybe you can excuse one but when they know a patient is prone to them, I'm appalled, absolutely...*

Ward 10 was an exceptionally large ward in those days. I don't know what it is like today but it was like a crossroads, basically, and the reception desk was in the middle of these crossroads. Nurses – nursing staff were very few and far between when we were there. Ward sisters, there was only about one which we could ever relate to. We could never find them.

64. I also heard about an 88-year-old woman, who had herself enjoyed a distinguished career in nursing, including geriatric nursing and 28 years of service with St John Ambulance. She was admitted to the trauma and orthopaedic ward in October 2007. The risk of falling was such that her family raised the issue with staff. Yet on the first night in the ward the patient fell out of bed and was found on the floor at 9.00am, according to the records. It is unclear how long she had been there before being found. Her family were not informed of this fall until they arrived for a visit. The family considered that they should have been informed immediately.

65. A 67-year-old female patient with mobility problems admitted to Ward 2 in 2006 experienced an incident in which she ended up on the floor. There was a record of the incident, which occurred on 10 September 2006, that read:

[the patient*] gave instructions to a health care support worker to transfer her to the chair with one person for support.* [The patient's] *legs gave way and was supported and lowered to the floor. No apparent injury, hoisted into chair, incident form filled in.*

66. The family understood, however, that she had been dropped by a member of staff who tried to lift her without assistance. Her daughter told me:

... the nurse did say she had dropped her. Those were her exact words to me... She said: your Mum has been very naughty, and this junior member of staff could not support your Mum. I said: well, wasn't it the junior member of staff's responsibility to say to my Mum, I am ever so sorry, [Mrs.....], *I can't do that; I am going to have to get some support; not to just leave her on the floor. Obviously at that point she would have known that my Mum had not very good mobility. I don't think for a minute my Mum expected this lady to do it on her own. She was expecting to either be hoisted or supported by another member of staff, but from that point, and I can clearly remember it in my head, she really struggled to push herself up the bed.*

67. Their belief was reinforced by the later discovery that the patient had at some point sustained fractured ribs.

68. For the purpose of this Inquiry it is unnecessary to determine the precise circumstances, at the very least this was an incident in which a frail woman was put at risk by being transferred from her bed by one person when there should have been two.

69. Another instance of a healthcare assistant attempting unsuccessfully to lift a patient with unfortunate consequences was the case of which a full account is given elsewhere in this report. This patient, while on Ward 11, was lifted and then dropped so that the spine hit the bed frame. The patient's daughter told me what happened:

Mum was only 4 feet 8. She was tiny. And what she needed – she didn't need lifting, but she needed two people either side of her, because the bed was higher. So she needed hoiking up. And one care assistant, she pressed the buzzer for help, but nobody came and apparently it had been so long and Mum was cold, that she tried to do it on her own. So she took her under the arm and Mum fell this way and fell back on to her bed and her back went on to the iron bedframe guard... my Mum was screeching... and then, as my niece woke up, my Mum must have blacked out, and Mum was half hanging out the bed and her feet by my niece because we used to sleep in the chair there. They put Mum back into bed and basically that was it. It doesn't seem that she was checked by anybody.

70. Another elderly patient with oedema, this time on Ward 6 in 2005, fell because she was wearing wet slippers and was left alone by a busy healthcare assistant to make her own way to the toilet. Her daughter described what happened:

A: *She said: I fell. And then the patient in the bed opposite called me over. And she said: I won't have a word said against Stafford Hospital or its staff but it is that care worker's fault your Mum fell.*

Q: *Why was it the care worker's fault?*

A: *She was rushing about, my Mum needed the loo, and she said to my Mum: are you all right to go on your own? And my Mum said: I think so, I have my frame. So she said right, and then she went. So my Mum was basically left to it, but her slippers were soaking because of all the fluid leaking out of her body. As I say, when I had asked my Mum why she was on the bed and she started crying and I said: what is the matter? And we didn't know anything about the leg. She said my head. I put – my Mum only had a small head. I put my hand on my Mum's head and I filled up with tears because my hand didn't fit round the lump on my Mum's head.*

Confused patients

71. Patients suffering from dementia or who are otherwise confused can present other safety issues for themselves and other patients. There was evidence that these were not always adequately addressed at Stafford. I heard from a number of families who had been concerned for the safety of their relative from the apparent risk posed by other patients. In one notable case already referred to above in relation to falls, the patient was subjected to an aggressive male patient trying to get her out of bed and trying to take her handbag. Her daughter told me:

We were basically terrified. The woman across the way had packed her bags, there was an aggressive man on the ward and he had actually tried to force my Mum out of her bed. He had grabbed hold of her and I had to intervene and try and coax him away from the room and he just had this fixation with the room. Just – as soon as you would try and take him out of the room – oh, where's your dinner, trying to distract him out of the room – he would be back in again and the woman across the way, she was – she packed her bags. She said I'm off, you know, he is going to hurt me...

There was two ladies and this lady in the bed opposite, she got out of the bed, she said: I'm going, I'm signing myself out, I need to get out of here. And she pressed the buzzer, it was just going and going and going, the buzzer was, so she started to get dressed and she collapsed on to the floor. So I tried to help her back into her bed, but meanwhile the man was back in the room after my Mum. He had grabbed the other woman's handbag and he was coming after my Mum. I just thought: I have had enough of this. I just can't cope with it any more.

72. When the daughter complained to a nurse she was advised to adopt self-help measures:

So I said: look, I said, what can we do? I said: this man, he is violent, the woman across the way wants to go home. I said: what can we do? I said: I'm going to complain. I said: who can I complain to now? It was a Sunday or a Saturday. I said: please, we have got to do something, I'm really frightened. She said: look, the best thing you can do is go back to your bay and push something up the door to stop him getting in, and tell the others to stay with their relatives, to stay with them. So I went back to the room and I pushed two of the trolleys – you know, the tables, two of the tables up the door, and we stayed – the other relative, she needed to go to work but she stayed until late into the evening and by this time everything was quiet.

73. Another patient on Ward 11 in July and August 2007 was actually attacked by a male patient who had already acted in a belligerent manner and was meant to be being observed because of that. I was told what had happened on an earlier occasion when the belligerent patient ran out of money to pay for his bedside TV:

In that earlier incident he was a very belligerent man. He had very sort of quarrelsome times with his visitors, but in this one instance, the money had run out on his television apparently and he couldn't get a picture. So what he decided to do was to go round everyone's bed in the ward and use their – try and get their televisions to work. Now, two young men in the opposite beds in the ward got up and went out. They had obviously, from what I could glean, had to get out of the ward before because of this man's nonsense, you know. And so they left and he then got on their beds, lay on the bed – on these patients' beds that had walked out. But before he did that he caught hold – of all the medical notes that are on the thing at the bottom of the bed, and he sort of slung them right to the bottom of the bed and he did that with both of them. Trying to get the television working. The nurse – one of the nurses came in and he was really rude to her, really rude. She tried to calm him down and I think she sort of just gave up and went away. And then he started on the next bed then, the same routine, through the chart down to the bottom of the bed, and then got on the bed and was trying to get the picture to go on and he didn't have any luck anywhere he went.

74. Before that incident I was told that there had been another occasion when the same patient had threatened two male patients.

75. It was after these incidents that the same man attacked the witness's father. His daughter heard about it from the consultant who:

> *... was visibly upset and when I saw his face I thought: this is bad news, something has happened. I thought perhaps they had found something else or, you know. He told us what had happened, but we couldn't believe it, could we? Just could not believe it, that this man had actually straddled – was on the bed with his hands round* [his] *neck... And the noise, I believe, was terrific because there is an elderly patient, a dear old man in bed opposite to* [his]*, and he said to me, he called me over, beckoned on the morning after it had happened and he said: I rang the bell. He said: the noise, the terrible noise woke me. He said: and I looked across and there was this man straddled on the bed; as I have been told, with his hands round* [his] *neck... He said he was petrified.*

76. The sister in charge of the ward told me in relation to this incident:

> *He should have been risk assessed and he should have been put on a one to one, which is a nurse looking after the patient, the nurse solely purely for that patient. But we have had incidents where the patient has been risk assessed and you have got the nurse on a one to one, and she turns round to go and fetch something and the patient could abscond off the ward for instance. This is a very extreme case and, no, I do not want it happening again because it doesn't matter who it is, it is somebody there who has been frightened. We don't have – it doesn't matter about staffing itself. Patients who become confused can become very agitated and become very physically strong. We have had windows been smashed before in the past, because patients are confused. By the nature of the ward itself, because it is an older age group, we tend to have patients who come in who are confused because they have been dehydrated at home, they live alone at home, they have been dehydrated, they have not been eating properly... So we tend to try our best to rectify the medical problem... I can't remember, what exactly that patient came in* [with]*. He came in, he was very confused and within two to three days he was back to what he was like. He was not a violent patient. We tried not to have violent patients.*

Dependency level and mix

77. One systemic reason for the incidence of falls and the effect on safety was identified to me by a senior nurse with reference to her experience in Ward 10, which I will return to when considering the issue of respect for the dignity of patients below. She told me:

> *... we have – on average a third of our patients have dementia. That can present in a number of ways. It can present that they wander; they fall; they are incontinent* [in] *inappropriate places; it can be that they set off fire alarms; they can be violent; they can interfere with other patients. A whole range of things... I have concerns that these patients cannot be cared for with people without cognitive impairment, because for that group of patients who are very ill and very frail sometimes, to have somebody try to get in your bed, or taking your things or trying to put your clothes on or, as I have had this week, trying to attack you and throw jugs of water over you because you are the devil, or whatever it may be is extremely frightening and patients are scared to go to sleep and everything else.*

Comments

78. These incidents suggest that patient safety was not adequately assured, particularly in wards where there was a high incidence of dependent and confused elderly patients. There is evidence that risk assessment and observation were required, but it is clear that neither was uniformly applied consistently or effectively. Incidents of the gravity described above should not be able to happen or continue for more than an extremely short time on a well run and adequately staffed ward.

CHAPTER 3
Personal and oral hygiene

79. The Essence of Care benchmark for personal and oral hygiene is that patients' personal and oral hygiene needs are met according to their individual and clinical needs. A patient's environment and the assistance provided to each patient must be acceptable to each individual patient, and the needs of each individual should be regularly assessed.

Assistance

80. I heard of many cases in which families felt obliged to spend extended periods of time attending to their relatives' hygiene needs.

81. For example, the daughter of a 71-year-old woman in Ward 11 in January 2009 told me:

... just taking care of Mum's everyday needs, getting her to the bathroom, washed, cleaned, dressed. It was – tasks which I didn't think I should be doing. She was in somebody else's care. I'm not a nurse. I was doing the best I could to make her comfortable. We are talking about at least four hours a day, at least.

Q: *And that was seven days a week?*

A: *That was the whole time.*

82. The daughters of an 85-year-old woman who was a patient on Ward 6 in November 2005 told me that, despite providing her mother with considerable assistance in meeting her personal hygiene needs, she was made to feel as though she was in the way by nursing staff:

Q: *Did you get help with cleaning your mother up at all?*

A: *I used to change her clothes when I went in, her top and nightie and that.*

A: *We used to do it without asking.*

A: *I was going to say I didn't ask, I just done it.*

A: *It was really like they could have done with just the patients there and sod the visitors. They were just a nuisance, just a thing in the way.*

A: *To me, I could clean my Mum up, I could have got her commode, I could have took her to the toilet, I could have done any one of them things, but they didn't want me to. We were in the way.*

83. Others were actually prevented from helping:

She would have willingly gone with anybody if they had just showed us and said: come on, then ... stick your leg in here, let's go and let's try this shower, and I will stay with you and I will do it for you. Mum would have done it. Mum would have gone. But it just needed somebody. I offered to do it and I was told I could not because of health and safety reasons.

Failure to wash patients

84. The same family told me that the patient was not washed by staff for the four weeks she was on Ward 11 between December and January 2006:

A: *... even asked for a mop and bucket and then she says to them: why [haven't] you bathed my Nan; my Nan stinks, why haven't you bathed her?*

Q: *What was the response?*

A: *We have not had time today. She is on the list.*

Q: *How often was "I haven't got time today" or "In a minute" the response?*

A: *Four weeks.*

A: *She never had a bath while she was in there. She was due to have a bath the day she died.*

A: *They hadn't got a bath. They could not find a bath. I had seen in my Mum's notes where it says my Mum refused a shower. My Mum was petrified of showers. She could not see properly and for a lady that was a very proud lady – ...*

I did all Mum's washing and my Mum was so fastidious with flannels, face flannels, she would have one for her face, one for her body, one for down below and one for her feet. Every day there would be four face flannels, all white, all had to be boiled. She was in four weeks and I washed two face flannels, two. And those were like bloody concrete. Her washing bowl was always bone dry and she would say – the nurse would say: we are helping her. And I would say: it is funny, Mum hasn't seen anybody today, nobody has been to help Mum get washed today and get changed; and yet my Mum, when she lived in the community, she had carers to help her. And she had nobody in Stafford.

85. A similar experience was reported by the wife of an elderly man who spent time in Wards 6, 7 and 8 in January and February 2006, who she said had been left unwashed for a considerable period. Once he was about to be bathed when he was taken off for physiotherapy.

86. The wife of another 80-year-old patient, who was on Ward 7 from December 2008 to January 2009, noticed that her husband was always in the same pyjama jacket:

He would be in the same pyjama jacket and just didn't look like his usual smart self. He was a gentleman, really.

87. I heard from the daughter of another patient, who was on Ward 7 in July and August 2007 following an operation on a fractured femur, how her mother felt obliged personally to take her husband to the shower every day because the nurses had not attended to him:

I took my Mum to visit my father on one occasion. He was still on Ward 7. I think it was maybe a couple of days after he had had the operation. The nurses don't help with personal care for whatever reason, so my mother went in every day, she took him into the shower, managed to get him into the shower. I sat outside in case he fell or she could not manage him.

88. A man who was an inpatient on Ward 11 in June 2008 and was weak with *C. difficile* recalled being refused assistance in cleaning himself up by a nurse after an incontinence episode:

... he was, as I say, on the morning shift and he refused point blank to clean me up after I had been to the toilet, on the commode and he said: you have got to learn to be independent again. Well, I don't think refusing a patient a basic service wouldn't be all that much good to help me to find my independence again.

89. The husband of a woman who was 73 at the time of her stay on Ward 7 in 2008 questioned the medical notes of his wife, which recorded that his wife was bed bathed daily, her hair was brushed and her skin and oral hygiene needs were met on six consecutive days. While he accepted that she might have been bed bathed, she did not appear as though she had been washed properly:

I don't know where the bed baths come in because sometimes she was most untidy and where they get this hair brushed from, I just don't know, because people – there were several other people visiting [my wife]*, not just me, and they are saying to me: if* [my wife] *could see her hair, because she had a hairdresser come every week... because she needed to be clean and tidy for the weekend.*

I am just thinking: the hair wasn't brushed. It wasn't combed, I noticed that... might be the odd day, but not six continuous days like that.

90. The son-in-law of another woman who had been a patient on Wards 6 and 12 in 2006 told of the contrast between the way she was cared for at Stafford and later at Stoke-on-Trent:

When we went back the next day, [she] *was a different woman. Whereas in Stafford she had been slumped all over the place like that, in Stoke she had been washed, her hair was brushed, she was sitting up. You would think there was a well different woman, without a doubt.*

91. Even among those whose relatives were washed I heard some complaints about how late in the day it was before this occurred. It might be thought that the time in the day was rather less important than ensuring that washing happened regularly, but it remains important to recognise the impact of changes from routines patient have been accustomed to before their admission. The daughter-in-law of one patient told me:

Really, my Mum's being washed at 11.30 in the morning. It's too late. This is a woman who used to get up at 6.00 every day.

Poor personal hygiene practices

92. I was told of a number of incidences of poor hygiene practice. In relation to washing and grooming of patients, I heard of two completely unacceptable incidents.

93. The daughter of one patient told me that her father had reported that, while on Ward 7 in July 2007, he had been shaved with a razor that had been used on other patients. The razor itself was found by her mother in the bedside drawer. She was confident that her father was sufficiently fit to have given an accurate account of this.

94. A female patient on Ward 11 in January 2009 and her daughter told me that she was offered *"a communal bowl"* for washing in. They found this unacceptable and she used medicated wipes and a flannel dipped in a water jug. When she did try to go to clean her teeth and wash herself, she received no help other than from her family, and other patients were in the same position:

I spent the whole fortnight in there washing myself with medicated wipes that people brought in for me, a flannel which I just wet from my water jug, and when I went eventually – could help myself somewhat with one hand, when I went to clean my teeth, which I couldn't do very easily, I tried to wash myself then.

Q: *I think from what your daughter said a moment or two ago, it sounds as if she helped you with your personal hygiene?*

A: *Absolutely.*

Q: *What would have happened if either you hadn't been able to do that or your daughter wasn't there?*

A: *Nothing.*

Q: *Could you see how other people were coping?*

A: *No one was being washed... the care workers were the chief carers on the ward. They were not supervised and what they did was very basic things like, I presume, washing hands and face. I never saw anybody bathed or anybody's hair being done, or anything but the minimum of care.*

Poor oral hygiene practice

95. I heard accounts of inadequate mouth care. The daughter of one man in the emergency assessment unit in July 2007 complained that, although he had mouth ulcers, mouthwash was not given unless the family asked for it:

Because his mouth, in such a short time, had gone – he got like ulcers in his mouth, hadn't he? After a few days. Do you remember, all dry and his lips were all cracked and I asked for a mouthwash, bring a mouthwash so I could clean his mouth...

Q: *You say you asked for a mouthwash or something to help soothe his mouth?*

A: *Everything you wanted, you had to ask for... From the most simple thing to the vital, really, you have got to ask for, whether it was a drip, a mouthwash or painkillers.*

96. The patient's daughter added:

They left my father with a crusted-up mouth, a furred-up tongue; nobody had even gone to wash his mouth or clean his mouth out with a swab or anything. You can get lemon swabs, you can swab them out and keep the mouth fresh. But nobody had done that.

97. The patient's niece, herself a nurse who worked at Stafford Hospital on another occasion, on Ward 6 in September 2005 had to demand attention for her grandmother's oral thrush:

But my niece worked at Stafford Hospital and she was – she had been in all the wards and she is now a district nurse and she visited quite regular and she was: excuse me, could you look at my Granny's mouth because she has thrush;

and excuse me, can you look at my Granny's heel, it is just about to break; and excuse me, could you look – we used our niece because we were fobbed off.

98. An 80-year-old patient on Ward 7 in December 2008 and January 2009 had debilitating oedema, among other problems, and developed oral thrush. His wife was convinced that the staff would not clean his mouth or teeth if she did not:

    Q: *Was he able to clean his teeth all the time and wash his mouth?*

    A: *First of all he was. And Sister came and spoke to him and spoke to me too about it, and she said: you must give him a new toothbrush every fortnight. And they gave him some statin... drops. But later on when he wasn't so able to move around, they never gave him facilities and I would do it for him. In the evening before I went... home, I had to do it for him.*

    Q: *Did you do it for him because you didn't think the nursing staff would assist?*

    A: *Because I knew they would not. He was so uncomplaining, wasn't he?*

99. The wife of another man on Ward 6 in September 2006 also found no care was given for oral problems:

    His mouth had been swollen, his tongue was swollen, he was covered in blisters. They gave him nothing at all for his mouth. What they suggested was he cleaned his teeth after each meal. He wasn't eating meals. They never gave him anything at all for that.

Failure to wash hair

100. Many patients will have taken great pride in their appearance and some will understandably attach great importance to their hair care. It may be distressing, particularly for an elderly patient, to be left in a dishevelled state still worst on public view. This important fact escaped at least some of the staff.

101. I heard from the daughter of a 79-year-old woman who was a patient at Stafford Hospital in December 2006 and January 2007. She told me that her mother went a considerable time without her hair being washed and, despite nursing staff continually telling the family that they would do it, her hair was never washed.

    I asked them to wash my Mum's hair because she had had her hair done for Christmas. For Christmas – on Christmas Eve she had had her hair done. She never had her hair washed again all the time. I kept saying to them: if you can't get a hairdresser or if she can't have her hair done, can I get somebody in, because my Mum, in all the years... my Mum always had her hair done.... My Mum's hair was her pride and joy... Her hair was snow white, but she still had her hair done every single week. She would always make sure that... there was always enough

money for her to have her hair done... I offered – all my friends were hairdressers but, no, we will get that done, we will get that done.

Comments

102. Many frail and ill patients will require a great deal of assistance in maintaining their personal hygiene, and it is clearly basic nursing practice to ensure that all are able to wash or be washed regularly and maintained in the general condition they would want to be. Failure in this regard challenges and degrades patients' humanity and aggravates the effects of illness, disability and separation from home and familiar surroundings. A wholly unacceptable standard was tolerated on some of the Trust's wards in respect of significant numbers of patients.

CHAPTER 4

Nutrition and hydration

103. The provision of appropriate food and drink to patients is not an easy task. Many will have special dietary requirements, either generally or because of the demands of their planned treatment. Others, particularly the elderly, will have difficulty feeding themselves and will require assistance in choosing food and consuming it. It is vital for the health and welfare of all patients that these needs are attended to constantly.

104. The 2001–03 Essence of Care benchmark for food and nutrition points to 10 factors for which best practice benchmarks are proposed, many of which have emerged as concerns in this Inquiry.

105. The problems that patients and their families faced with obtaining appropriate meals and drinks occurred again and again in the evidence I heard at the oral hearings. Approximately half of the people who gave evidence mentioned this as an issue. The specific concerns that have emerged from the oral and written evidence to this Inquiry are:

- lack of menus
- inappropriate food given to patients in light of their condition
- patients not provided with a meal
- patients' meals placed out of reach and taken away even though they have not been touched
- no assistance provided to patients to unwrap a meal or cutlery
- no encouragement to patients to eat
- relatives and other visitors denied access to wards during mealtimes
- visitors having to assist other patients with their meals
- visitors prevented from helping patients with feeding
- no water available at the bedside
- water intake not monitored or encouraged
- problems with drips not addressed adequately
- lack of monitoring and appropriate records of fluid balance and nutritional intake.

Lack of menus or other presentation of choice

106. A man who had been on the emergency assessment unit in October 2008 told me that he had diabetes but that the menu provided did not make it clear what was suitable for someone with that condition. No diabetic menu was offered:

Well, the first morning, obviously, I was – like they do, they give you a diet – a menu, you pick your meals. I filled that in to the best of my ability because I knew I had got sugar, so I knew – I thought, well, I can't have anything – but nobody explained how much sugar is in what, so I had to guess what it would be all right for me, and that was – I never saw another – all the time I was in there I never saw another menu, and every time I said: well, you know, is there sugar in this? Oh, I don't know. Oh, no, there's no sugar in this ward, and yet on the tray, as you pointed out, two sachets of sugar.

[Patient's wife]: *I got shouted at, I got shouted at for it.*

[The patient]: *And when you point that out: so, if there is no sugar on this ward, what are they doing there, you were told: they are for drinks...*

Q: *So one of the things it sounds like you wanted was a menu which explained what was in the food, which ones had sugar, which ones don't.*

[Patient's wife]: *They don't seem to have a diabetic menu.*

[The patient]: *I take it that, because I was on a general assessment ward, that everybody has different needs, which I understand. But my need at being a diabetic should have been taken into account, surely, that I had to guess – they stood at the end of the – the end of the ward, like, and she shouted up: dinner, who wants it? What you got? And they told you what you'd got and you'd got to tell them which one you wanted.*

107. The daughter of an elderly man on Ward 7 in 2007 noticed that many patients were incapable of filling in the menu cards provided and received no help:

Obviously you get a menu the day before which you have to fill in ready for the next day, and there is a lot of elderly patients on Ward 7 that don't have anybody visiting them at all. Mum used to fill in the menu sheets for him. For other patients they didn't get them filled in, as far as we could see. There was no help for them – for the patients to – there was no help for the other patients to be fed. Obviously my mother helped my father. The other patients didn't have anybody, so were they fed or not? I don't know. My mother was actually helping the other people in the wards.

108. It does not appear that the provision of choice was properly managed on at least some wards.

Inappropriate food given

109. I received many complaints that patients could not obtain food appropriate for their condition, or were not given what they had ordered. In the case of a person with diabetes, it is of course essential that a correct nutritional balance in maintained, as is the case for other conditions. Even where it is merely the patient's choice that has been thwarted, the detrimental effect on morale is undesirable and to be avoided if possible. Admission to hospital results in an inevitable loss of a degree of independence, privacy and dignity, but this should be minimised. I found it particularly noteworthy that there appeared to be little evidence that these omissions were appropriately recognised at the time and followed by remedial action or even an explanation. Mistakes will of course be made and shortages of particular items will occur, but it would take little effort on the part of staff to indicate to the affected patient a degree of empathy. At the very least this can offer reassurance that staff are doing their best to promote patients' welfare, even if this is difficult for them at times.

110. One patient in Ward 2 in August 2006 had been advised by her consultant that she needed protein and was encouraged to eat red meat. Her daughter filled in a menu card to order cottage pie, but this is not what was supplied:

I actually went in that lunchtime to see Mum sitting there looking at a plastic cheese salad that was in a plate at the end of the bed that she could not reach with an orange that she couldn't peel... I found an auxiliary and they said: oh no, that's what your Mum ordered. I said: no she didn't because I wrote the sheet, I wrote the menu sheet; she had ordered cottage pie. No, no, no, it was definitely a cheese salad... I then went out, back into the town to buy her something to eat, came back and fed my Mum.

111. A patient who had been nil by mouth for several days was then provided with food, after which he was violently sick:

When eventually they gave him something, they gave him some jelly and ice cream which he managed to get down. And then they gave him a banana sandwich on the night, which I thought was a bit much considering he had not eaten anything for nine days. I thought it would have been a slow process of build-up and then to go on to the stodge food which I knew he would have to have. He was violently sick afterwards...

Patients not provided with a meal

112. One elderly woman on Ward 11 in January 2009 often had difficulty obtaining a meal. On more than one occasion:

Sometimes even though I had filled in the menu sheet, I didn't get a meal. Very often didn't get a meal.

Q: *What, nothing?*

[Patient's daughter]: *Nothing. They would give her what was left.*

[Patient]: *That's when Paula would go and look to see what was left in the trolley to see what she could get for me out of the heated trolley in the corridor.*

Q: *Do you mean that the food would have been passed around – passed out and you were missed out, or you didn't get the meal that you had ordered?*

A: *No, I didn't get a meal.*

Q: *Nothing at all?*

A: *I had ordered it. What happened to the order, I don't know, because all the meals were given out and then there is nothing left. I think they used to send some extra things for such an event, like if there had been an admission. So I often had what was left over.*

113. Another woman had similar difficulties while on Ward 10 and during her discharge. She had a bad experience waiting most of the day in the discharge lounge. On the latter occasion, her daughter told me:

I sat with my Mum all day there, it seemed all day and it probably was, because – they must have had lunches though probably – because Mum had nothing to eat or drink and I caught a young person walking by. I said: my Mum is a diabetic and she is supposed to have something to eat. "I will go and find something". He came back and he had a shop bought trifle like that and he went, "this is all I can find". I thought all you can find in a hospital? And this will have to do. I mean my Mum wouldn't even look at it. In all fairness to them she probably wouldn't have eaten anything they brought, but they didn't bring anything, they didn't even try to give her anything.

Meals placed out of reach and taken away even though untouched

114. I heard from many families about how food was left out of reach of the patient. It should be appreciated by staff that some patients, particularly the elderly, are unlikely to be able to reach far for a tray or other form of food transport. Indeed, many younger patients will be in the same position. It is obviously important for staff to ensure that food is left within reach, and if they see it has not been touched to correct the position and ensure that the patient has a proper opportunity to eat what is provided. This simple and essential practice seems to have been omitted on an alarming number of occasions in Stafford.

115. The wife of a patient on Ward 10 in October 2008 noticed that food was not put in his reach:

There would be sweets or fruit or drinks on a table out of his reach. This is a common thing in hospital, that the person who brings the food doesn't put it within arm's length and make sure that they are propped up enough to eat it. If you are lying down, you can't reach it or eat it.

116. The son of a 90-year-old woman who was in the EAU in October and November 2008 told me how his frail mother had been provided with sandwiches wrapped in cling film; while he thought she might have been able to manage to unwrap the food, it was left out of reach:

When the doctors had gone, this is gone 6 o'clock, I noticed there was two sandwiches that had been placed completely out of the reach of my mother and I asked her if she was hungry and she said: yes. I said: would you like a sandwich? And she said: yes, I would. And I gave her a sandwich and she was able to eat that sandwich herself, but it was completely out of her reach. If no one had been there to help her, she would have not been able to access food without help.

117. The wife of another patient whose food was left out of reach in Ward 12 was asked to come in to help feed him on the claimed ground that he was refusing to eat:

I was at home and she rang me. She said: your husband is refusing his meals. So I says: really? She says: yes, I think you had better come in and feed him. So I said: certainly I will come. And I went in every day afterwards, but when I went into him, I was blazing. I said: look, why aren't you eating your dinners? I said: you have to eat your dinners to get better and come home. He said: it isn't that I'm not eating them, J... I can't reach them. And they were on the brown thing at the bottom of the bed. He could not stand up so he could not get them. The chap next to him, he got Alzheimer's, he had got tomato soup with a lid on, he got rice pudding with a lid on, he had got sandwiches in cellophane. They can't do that when they are ill. They just can't.

118. On another occasion she arrived to find his food had been taken away:

I went in one day... and his dinner was not on the bottom of the bed and I said: where is your dinner? And he says: she took it away. I said: why? He said: I don't know, I couldn't reach it. I went to see the nurse and I said: excuse me, Mr [...] *Oh, we have cleared away. She says: the doctors' rounds. I said: well, I am sorry, he has had nothing to eat. She brought me two yoghurts. So I went down to the shop and fetched him a sandwich, but, you know, it is...*

Q: *Was any explanation given as to why it had been taken away?*

A: *Because he hadn't ate it, because he couldn't get it. But there was no sister available in that ward on that day either. I wasn't a worrier, you know, I wasn't a troublemaker or nothing, but when it's my own, I like to see things done properly.*

119. I was told by a witness who visited her elderly mother on Ward 10 in September 2007 that a tray of food was left on a table at the end of the bed:

A healthcare assistant came into the room, didn't acknowledge us at all. She just walked in with a tray and... she just put down the meal and just walked out the room again. The woman hadn't spoke to us at all. She was totally confused. And I just turned round – I said: are you having your dinner, love; and there was no response whatsoever, and she just kept eating out this little sweetie, like little jelly babies she was eating, and the dinner was just there, but further away in front of her and the sweets were here.

Q: *Were you able to tell: was she capable of reaching for the food?*

A: *No, she was immobile.*

Q: *Right.*

A: *About 15 minutes later, the healthcare assistant came in and just picked up the meal – the film was still on it – and just went to take it away and I said: she hasn't touched her food. She says: she never does; and just walked out.*

No assistance provided to patients to unwrap a meal or cutlery or to eat

120. Some examples of this have been given above.

121. The son of an elderly woman who was on Ward 10 in 2008 told me that his mother's meals were placed out of reach, and even if they had not been, she would have had great difficulty in unwrapping and using the cutlery provided because of her arthritis, not to mention her dementia:

[Patient's son]: *This is the ward where we would go in in the evening or the afternoon and say: what have you had for a meal. And she said: they haven't been round today. But this was part of dementia setting in, we think, but it is recorded here, where meals were taken, but having said that, bear in mind that Mother's sight was on the way out and she had arthritic fingers and that. We feel that she couldn't even take the cling film off a plate when salads were round.*

[Patient's daughter-in-law]: *Her fine motor controls were so weak at that time. How could she handle cutlery? She couldn't. There was very little that she could do and we feel the food was just put there and left and nobody sort of cajoled her. She may have said: I don't want that. She needed encouraging because, you know, when you are ill and your palate – it needs tempting and it seems – I don't know, it seems to me as though she almost starved to death on that ward, because she lost weight rapidly in her later days.*

122. Another patient who was on Ward 11 in early 2009 told his wife that breakfast got taken away before he had finished it:

I wasn't there when he took breakfast, but he did say that during breakfast, the nurses would feed him and at some stage he liked to lean back on his pillows for a rest and that they would take that as an indication that he had had sufficient, which in fact wasn't the case.

123. Clearly it is very important that food is not only provided but that steps are taken to see that it is consumed and, if not, to ensure that appropriate nutrition is provided by other means. I could have no confidence that this was occurring at Stafford during the relevant period.

No encouragement to patients to eat

124. It is clear from the accounts I have summarised that little if any encouragement was given on occasions when it was needed. Many patients, particularly the elderly, may be reluctant to eat food to which they are unaccustomed, or may be confused or forgetful. While relatives and other visitors can help, they will not always be there and staff help will then be required. I heard of too many instances where this was obviously not offered.

125. The granddaughter of a 78-year-old man on Ward 11 in the late summer of 2007 told me:

My Granddad was sort of, very particular about what he liked to eat and he probably, compared to my Nan's cooking, thought this is not the most appetising food... I remember there being food there and him being questioned by my grandmother, interrogated as to why he had not eaten the food that had been provided. I don't know whether had he had somebody there saying: come on, [patient name] *you really must eat this, you are a diabetic. I think if he had have – if he had had some pressure applied, he probably would have eaten more, but left to his own devices, the food would have just been wheeled in and wheeled out with nothing gone and nobody saying: well, actually, you haven't eaten anything.*

126. The daughter of an 86-year-old woman on the trauma and orthopaedic ward in November 2007 told me that she did not think efforts to encourage eating were adequate:

I mean, some days – it was half a teaspoon of carrot one day. Another time she went 20 hours with just half a cup of tea. Until we went in there, there didn't seem to be any food at all, and although I was told they were encouraging her to eat, I stood back and watched the encouragement and they sort of came along: [...] *do you want anything to eat? She would say no and they would put the lid on and walk away.*

Relatives and other visitors denied access to wards during meal times

127. I heard from a number of witnesses who felt restricted in their access to patients because of visiting hours. These did not include meal times, with the result that some relatives felt pressured not to be there then to help with feeding. While the more forceful and self-confident felt able to overcome this, not everyone did.

128. One witness told me:

I think the initial comment of the nurse which said: we don't like you visiting during mealtimes; if I had accepted that, I don't think my Mum would have eaten anything for an important time in her life, when she should have been eating to get stronger. So I think that, if said to people – okay, people at mealtimes is a nuisance, I understand that. But people who aren't being fed and who can't feed themselves, if they can have visitors, that would help them; I think that would be useful. But I understand that you don't want a lot of visitors cluttering up your ward when you have other things to do. I am still glad I did it and I would do it again.

129. One relative of a patient in Ward 8 thought that visiting was allowed flexibly except for meal times. This was gathered from a notice at the ward entrance.

130. The family of another patient who stayed throughout the day to be with their relative felt they were *"told off"* for being there. Some thought that *"in a big hospital you have got to have rules"* but that *"it would have been lovely"* to have some flexibility. Another patient's daughter was given the impression that *"there was no choice.* [The nurse] *told me to go out because it was only 2.58."* Another witness, who had retired as a nurse many years previously, acknowledged that in her day visiting hours were strictly observed, but she felt that more flexibility would be desirable and that it would be possible for nursing tasks to be undertaken while visitors were present: they could be asked to move away temporarily. However, the daughter of a patient in Ward 11 found that she was allowed to visit whenever she wanted and was grateful for that.

Visitors having to assist other patients with their meals

131. The woman referred to above who was asked to help her husband in Ward 12 found herself helping a number of other patients:

Once I had been giving his dinners for perhaps a fortnight, would I go in and do his teas? I was doing ten-hour days at the hospital. I enjoyed it. I really did enjoy it, I can't say I didn't, because I did. I was seeing my husband and I was helping the other people and it was quite enjoyable.

132. She helped about four or five patients every day.

133. Another family whose relative was in Cannock Hospital in 2007 was asked to come in to help feed him when they complained about the lack of support:

When we were initially aware of the fact of that lack of support, we sort of raised the issue with the ward sister, and we were invited to come in ourselves at lunchtimes, for the evening meal, to assist our mother ourselves. So at that stage we took that to be the normal thing that happened in hospitals. Subsequently, for the entire period, that is what we did. My sister, she works from home, was able to come in for the lunchtime meal. I am in full-time employment. I had to ask for my hours to be amended so that I could leave work early in the afternoon in order to get to Cannock Hospital in time for the teatime meal.

134. They did not object to being asked but, as they pointed out:

I think that is fine as long as it isn't dependent upon [this]*, because there are a lot of people who do not have relatives who are fit and able to go in and so what happens to them? You see, the most vulnerable are going to be the ones who, because they have little support or they don't have relatives who can go in and help, what happens? I mean, we helped others in the ward, didn't we, while we were there. We were going round and we were taking lids off drinks and we were helping to put things in reach.*

Visitors prevented from helping patients with feeding

135. I have received a number of accounts of visitors of one patient feeling obliged to help feed others who had no one to help them. However, others appear to have been discouraged from doing this. Meal times are for many a welcome occasion for socialising, and there is no reason why this should not be encouraged in hospital, subject to the therapeutic needs of all the patients in the ward. Any restriction on visitors' access at meal times should be the least necessary. This does not seem to have been recognised.

136. The wife of a patient who lost two stone while he was in Ward 10 in October 2008 was one such visitor:

I was not encouraged to go in at meal times and I think a lot of sick, elderly, infirm patients need help with their feeding and they don't get it.

A reason for this may be suggested by the evidence given by an 89-year-old woman who was in hospital between February and March 2008:

Q: *How often did you notice people not eating their food, it just being left?*

A: *I saw it when I was going to the loo and back, and you would see it sitting there for quite a while. Of course I wasn't allowed to interfere or anything. Later, when I saw* [the Chief Executive]*, I did say: I would be happy to go in twice a week and feed some of patients. I said: malnutrition is a very serious problem for old people. And he said: I am afraid you can't; health and safety wouldn't allow it. So you can starve but you can't be fed.*

No water available at the bedside

137. Although, as I have already indicated, I did not receive evidence about the alleged 'vase' incident, many witnesses told me of difficulties encountered in obtaining water on different wards.

138. The son of the elderly patient who had food left out of her reach in the EAU also had difficulties getting water. She had been provided with no water along with the sandwich in that instance, but the problem was constant.

My mother, I must say, was on a saline drip. They had indicated that she was extremely dehydrated, which in layman terms to me means you need water. Every time we went there was no water by the side of her bed. My wife had to go and ask for water each time and Mum always wanted water. It was always provided in a beaker, like the one you have got in front of you over there. That is how the water came. They never gave her a jug of water. It was just provided in a beaker. Because she had lost the use of her arms, we had to give her the water that way. We found it difficult, insofar as that my wife went out and she actually bought a beaker with a lip that my mother could actually use, but unfortunately we were too late. She was never able to use it. We were forced in that situation that we felt that we had to go and get a special mug for Mum to drink out of, because each time we asked for water, although they knew she had no use in her arms, we were given water in a glass like that.

139. The same witness also experienced a concerningly dismissive attitude towards this problem from one senior nurse.

I mentioned the fact to you that I was concerned that my mother wasn't being given fluids, and also I wanted to know the outcome of my mother's first fall, and they said that they would actually look into it and get in touch with me. I did receive a telephone conversation from a Sister. [She] *told me that they weren't giving my mother water because she was spilling it.*

140. The daughter of a patient in Ward 11 in September 2007 described the difficulties she had faced in getting water for patients there:

But I would say to the nursing staff... would you leave water out at night? Night after night after night I asked for them to leave water for the patients. We can't. I said why? Because the jugs have to be washed. It didn't matter – they just wouldn't leave – I said, well, they get up – because that was day to them, they wanted feeding, they wanted something to drink, and they would just wander around everywhere looking for this drink. And they were just as cold as that, even after I had said to them: but they want a drink during the night. But we have to take the jugs away, they have to be sterilised. It is either that or infection. But they were just dismissive of the patients.

141. Even where water was at the bedside, insufficient thought could be given to whether the patient could use it. The daughter of one patient who was virtually blind, deaf and very frail, and was on the EAU in 2006, told me:

They offered her a soup, but quite often when I got there in the afternoon, the one time there was a ham sandwich and a whole apple and it was on a plate and a jug of water. She couldn't see the jug of water. She could not lift it to give herself a drink. She couldn't give herself a drink. She needed help doing that. Basically, she needed, like we were giving her, constant attention. Unless you are in a private hospital and so on, constant attention, it is not the nurses' and doctors' fault, there aren't enough of them.

142. This witness thought that vulnerable patients like her mother should have a member of staff specifically assigned to keep an eye on their needs and be available to assist where needed.

Problems with drips not addressed adequately

143. Some witness recalled problems with drips set up to ensure hydration in ill patients. I heard a concerning number of complaints that families had found drip bags which had run empty without the staff noticing this or doing anything about it. Again, the reaction of staff could be dismissive, as illustrated by one relative's recollection:

Again, my father's drip had run out. I went down and asked them to replace it. We will come in a minute, we will come in a minute. No. His painkillers were due, never got there. I think I went down four times for that. Eventually she came to change the drip. I went out of the room while they did what they had to do with my father. While I was standing outside my father's room, she came out to get something and on her way back in she said to me: if you don't disturb us, we won't disturb you. I said: pardon? She said: I didn't mean it like that. I thought to myself: you flipping well did, you would not have said it otherwise. Which upset me. I have asked them to do something and they don't want to do it, really.

144. Another witness told me:

It only happened on one occasion when I was present that the drip bag did run out, and so I went in search of a nurse and found a senior nurse and she took on board that it needed replacing, but as I believe I stated in my letter, it took literally hours for anything to be done.

Lack of monitoring and appropriate records of fluid balance and nutritional intake

145. My examination of the medical records of many patients suggested that proper records of fluid balance and nutritional intake were not maintained. In many cases, charts would be started but not continued, or filled in for some days but not others, allowing no picture to be built up of patients' progress. I very much doubt that such incomplete records would be any significant assistance in assessing patients' continuing nutrition and hydration needs. This deficiency was remedied in a striking way by one patient's family. The mother of the patient in Ward 11 in September 2007 referred to earlier, who saw her tray being taken away untouched, resorted to self-help in this regard:

... all the patients' files would be removed at night. Nothing would be added during the day. If you look at Mum's fluid charts and what she had been eating, all of those were filled in by the family. There isn't one entry on there that was filled in by any of the nursing staff. We filled those in ourselves because we were sort of managing Mum's food and fluids. I think that's – they were just taken away at night, all of the patients' files, the night staff would collect them all and then they would be delivered back to the patients in the early hours of the morning, and they didn't seem to correspond with what had happened during the day at all.

146. A system of monitoring by observing what was left in water jugs was said to have been used with some patients. This was not always effective:

... I shouted to the nurse and I said: excuse me, I said [the patient] *has had one and a half of the paper cups of water. And* [the nurse] *was behind the screen and she said: we don't need you to tell us how much she has had, we monitor the jugs because we measure them. I said: you might measure them all you want but my Mum doesn't like lukewarm water, and I brought this fresh from the shop downstairs, and I just carried on walking. They were supposed to be monitoring her input and output, so as far as they were concerned, she would not have been drinking anything if the jug was still full. My Mum had had a full bottle.*

Comments

147. The provision of appropriate food and drink must be one of the most basic and fundamental responsibilities of a hospital and its staff. As with all other aspects of basic care, patients are often unable to provide for themselves as they would be able to do in the community. However, while the need for nutrition and hydration is universal, each individual needs personal consideration. In some cases, little more than provision of an appropriate choice and delivery of the chosen food is all that is required. In others, more specialist care is required.

148. I have noted that the deficiencies identified were not confined to one ward or one period of time. Often, matters would have been worse had it not been for remedial action taken by relatives and other visitors. While there is nothing wrong in principle in visitors being asked to contribute to care if they are willing and able to do so, the provision of services in a hospital should not be on the assumption that such help will be available. Frequently, the explanation for what went wrong may have been a lack of staff, but, regrettably, on occasion staff were present but seem to have lacked a sufficiently caring attitude towards their patients. I have to conclude that there is evidence of an unacceptable standard of basic care being provided as a result of systemic failings. What has been shown to this Inquiry is more than can be explained by the personal failings of a few members of staff.

CHAPTER 5
Pressure area care

149. The occurrence of pressure sores in a patient being cared for in hospital is always a cause for concern and frequently indicates a lapse from an acceptable standard of basic care where the patient is immobile. One witness, a retired nurse of many years' experience, who came to tell me about her personal experience of care at the hospital was quite firm about what the expectations were in her day:

    Q: *When you were a nurse, did people ever get pressure sores?*

    A: *Very rarely, and you were on the mat for it if you did. This is a very, very important thing. It was a matter of shame if you got a pressure sore... We had to twice a day go round with a tray, whatever your rank, you went around every patient, you rubbed their elbows, their heels and their back with – first you did it with soap and water and then you wiped that off and then you rubbed it with spirit and then you rubbed it with – powdered it with talc. That was a twice-daily routine. That is why we didn't have bed sores. We very rarely got an abscess, very rarely.*

    Q: *Was that particularly time-consuming?*

    A: *Yes, but it is part of the nurse's routine.*

150. I asked another former nurse whether bed sores ever happened in her career as a nurse. She replied:

    Woe betide us if we did.

151. The Essence of Care benchmarks of best practice highlight the importance of: screening individual patients at risk and developing with family members individual plans for patients to minimise risk; repositioning of patients and supporting structures; and the availability of the right equipment to prevent the development of pressures sores.

152. Unfortunately, these standards were not always met at Stafford. Some 16 people contacting the Inquiry described experiences of pressure sores developing. The retired nurse mentioned above told me about how, while her husband was being treated in Stafford, he developed a bed sore which she described as "*terribly sore*". She was sure that this would not have happened in her day as a nurse. She described the simple measures they took then to prevent these sores:

We used to rub it, massage it, with soap and water... [It took] *only a matter of a few minutes really. We would have a trolley; go round doing all the patients' backs.*

153. She did not think that the nursing staff at Stafford would have had time for this as there were not enough of them.

154. Another witness told me how a pressure sore her mother had incurred before her admission to Stafford had been resolved while she was being cared for by her family at home with the assistance of a pressure-relieving air bed. After her admission, the patient's sore returned. Her daughter told me:

The pressure sore came back. By the time we got her back from the hospital, the pressure sore came back and she was only in there Monday afternoon to Thursday, and we fetched her by 5 o'clock on the Friday and the pressure sore had come back again. I do not think we ever got are rid of it after that.

155. I received characteristically thoughtful advice from the General Secretary of the Royal College of Nursing on this subject.

... with... people that are seriously ill, sometimes it is very difficult to avoid pressure sores, but they should be at an absolute minimum. You will hear from people – from different eras – that would pride themselves that you would never see a pressure sore within a ward. I still go to lots and lots of hospitals where they can demonstrate that they don't have pressure sores, but to say never, it would be very, very difficult, but they should be at an absolute minimum. Where you have a high incidence of pressure sores, that is definitely an indicator that something is fundamentally wrong. Again, not wishing to jump around, but as part of my visits I was also invited to meet the group known as Cure the NHS, and I spent a Friday afternoon with them at the café and I saw photographs of pressure sores there which frankly were truly shocking. I have never seen anything like it. Really gruesome and a very sad indictment of what was going on. I don't know if those were people that had the pressure sores and were admitted and they got worse, or whether or not they came in without the pressure sores and developed them, but either way, it was as bad as it gets.

156. Another patient who was treated on Ward 1, 7 and 11 developed bed sores because, according to his family, he was not moved often enough – which they understood to be a basic requirement for avoidance of sores in immobile patients:

[I helped] *to change my Granddad, because as you can appreciate, to roll somebody over onto their side, they needed two people to do that and there were not two available. There was one available and they needed to wait, and I said: well, I will help you. And she asked me if I was a nurse and I said: no, but he is my Granddad, it doesn't matter.*

Q: *Was any explanation given to you as to why he developed pressure sores?*

A: *I think it is just because he had been in the same position for a considerable amount of time, and after the incident with the insulin, he wasn't really up to getting out of bed and moving about, which is what he should have done after a hip operation, would be to do this gentle exercise and walking with a stick, and it didn't really happen once the diabetic coma had occurred.*

157. The care of patients who arrived with pressure sores was not conducive to recovery from them. The family of another patient who was admitted to Stafford Hospital in December 2007 and later moved to Cannock told me that they could not obtain a special pressure-relieving bed for her without making very firm demands.

Comments

158. It was not possible to undertake a full audit of pressure care, nor was it necessary for the purpose of this Inquiry. It was not, however, surprising to learn of cases of patients having pressure sores given the accounts I heard about general standards of care. Vulnerable and frail immobile patients will always be at risk of developing pressure sores, and impeccable skin care is required to avoid them. Given the shortage of staff and other obstructions to the provision of care, it was inevitable that cases of avoidable breakdown of skin integrity would occur or persist. While there was evidence of assessment forms being available, it was open to doubt whether these were consistently used. As will be seen, there appears to have been little proper multidisciplinary team working at Stafford, which is essential in this area if proper care is to be provided.

CHAPTER 6

Cleanliness and infection control

159. It goes without saying that patients and visitors to hospitals are entitled to expect a high standard of general hygiene and cleanliness. This is important for the control of infection and also because clean surroundings give assurance that the hospital is well run and focused on improving the health of those who seek its help. Guidance suggests the following should be considered in relation to whether best practice is being applied to keep the environment clean:

- the internal and external areas are clean and there are no avoidable unwanted odours;
- cleaning arrangements are flexible to meet the needs of patients;
- adequate hand washing facilities are available for people;
- regular routines for cleaning and managing waste are in place that meet the national standard;
- all areas are checked for cleanliness on a regular basis;
- cleaning equipment is readily available and stored appropriately;
- patients are enabled to raise concerns about cleanliness and request that action is taken; and
- systems are in place to deal with spillages and emergency clearance 24 hours a day.

160. It might be thought that Florence Nightingale put it more succinctly:[20]

Very few people, be they of what class they may, have any idea of the exquisite cleanliness required in the sick room... the sick man who never leaves his bed, who cannot change by his own movement of his own the air, or the smell, or the dust; he is really poisoned by what to you is the merest trifle.

161. Many patients and families have remarked on the lack of cleanliness in a variety of wards throughout the period under review. I have been given descriptions of dirty toilet facilities, bed frames and other ward furniture, floors and walls. Spillages, commonly of urine or faeces or blood, have been left in patient areas for far too long. There has often seemed to be an absence of systematic and effective cleaning. Staff have been observed adopting poor and unsafe hygiene practices, and on occasions families have been given inadequate information about hygiene.

[20] *Notes on Nursing*, Nightingale 1860

Infrequency of cleaning

162. Some families told me how rarely they saw wards being cleaned even though they were attending their relative constantly.

163. The daughter of an elderly woman in Ward 11 in 2007 told me:

> *The only time I saw two trained staff... in that bay was a Sunday afternoon, when two – a sister and a staff nurse – came in with a bucket each in their hands and they proceeded to clean the lockers and the beds, a sister and a staff nurse on a Sunday afternoon. All the relatives were there and they cleaned the bay. I have never seen my Mum's locker, bed or anything cleaned during those eight weeks, but that Sunday afternoon they were cleaned by a sister and a staff nurse, and that is the only time we saw two trained nurses together. The following day there was an inspection, but now I know it was by Monitor.*

164. Others told me of occasions when cleaning was done regularly but without any degree of thoroughness. One patient told me of her experience of Ward 11 in 2009:

> *They tell me that* [Ward 11] *was cleaned twice a day. Somebody came round with a bumper thing and went round with a wide mop, mopping round obstacles, and I can say that several times I asked the lady, did she want me to move my legs so that she could get round. She said: oh, no, don't bother. So she just mopped round me. If there was an obstacle in the way, it didn't get moved. I wasn't very aware of cleaning, really.*

165. The daughter of a patient with *C. difficile* was being nursed in a side ward on Ward 2 did not witness any cleaning, despite her mother's condition:

> *... it was absolutely filthy. We cleaned it daily. I had never seen so much dust in my life.*
>
> Q: *... First of all, in the time that you spent in the room, did you ever see a cleaner at any point come in?*
>
> A: *The day before my Mum died, this was on 12 December, she came in and said: would you like me to clean now? I said: with the greatest of respect, there doesn't really seem a lot of point now, does there?*
>
> Q: *I ask this, maybe it is wrong, but it would seem surprising if there had been no cleaner in the course of four months but you didn't see one?*
>
> A: *I didn't see anybody, unless they came in the periods that I was not there or the times in the day that I was not there, no, I didn't see anybody.*

Observations of the dirty state of wards and furniture

166. The family of an elderly man admitted to Ward 7 in 2008 had to ask for cleaning to be done:

Within the first day of his admission to that ward, I had actually specifically asked for the sides of the bed to be cleaned because there were faeces on it, and I did ask a nurse and she did go off and cleaned it.

Q: *It took you to point it out?*

A: *Yes, it did.*

167. Another witness referred to the bins in Ward 8:

Q: *... you also make the point that bins were routinely left overflowing?*

A: *That's right. Especially the bin where [the witness's husband's] room was, it seemed as if they came in and dumped all kinds of waste in, like there was a little entrance vestibule with a sink. That was just piled up...–*

168. Another couple observed blood stains left the floor for some time on Ward 10 in 2008:

A1: *We used to see quite a few blood spots on the floor.*

A2: *We used to follow those, not just in Ward 10, we used to follow them down the corridor: oh, they are still here.*

A1: *They would go a browny colour the next day. They hadn't been properly cleaned out.*

169. One family commented on clinical waste and blood left lying around:

A1: *There was blood; there was tissues with blood on the floor; the bin had got all clinical waste in it, which was there the next day.*

A2: *It wasn't just clinical waste, because I visited my mother when she was in there.*

A1: *There were sheets with blood.*

A2: *The soiled sheets were kept in the room in a bag for probably three – the whole time she was in there, those soiled sheets were in that bedroom.*

A1: *In a black bag.*

170. A patient who was in Ward 2 in the summer of 2006 had frequent blood tests but the resulting swabs were just left:

Mum was having frequent blood tests throughout her stay and on one occasion a nurse had come in and taken blood and left two of the swabs that were actually on the side, and this had happened a few times and there were some on the floor. I said to my brother at the time: shall we leave them there and see how long they actually sit on the floor? Because there was also blood on the rails that was on my Mum's bed. Three days later, I thought probably a good job if I move them now. They would frequently be left just scattered around, and we would pick them up and we would actually put them into the bin.

171. Another witness commented on the general untidiness:

... things like yesterday's newspapers, dust on the floor, tissues on the floor, uneaten food between meals in dishes not collected up. Lack of air in the ward, not having a window open and freshening it up when these men are soiling the bed... I would go in one day and tidy his locker, the top of his locker, and notice something, a bit of equipment or paper or something belonging on the staff, not to him, and it was still there the next day. I don't know what system they had for cleaning the ward.

172. As with many other deficiencies brought to light in this Inquiry, witnesses had different experiences in different wards. The husband of one patient contrasted the cleanliness on Wards 11 and 7. Speaking first of Ward 11 he told me:

... it wasn't one of the cleanest of places. It... seemed like a dismal place. It was painted pink and grey, which didn't help... but there seemed to be stains or old pictures on the walls. It didn't seem very clean at all, not compared to other wards I had seen in the same hospital. Ward 7 was clean and it looked clean, whereas Ward 11 didn't... The floors looked dirty and the bed we were put into – my wife was put into rather, there were previous stains on the floor. That seemed to be throughout the ward.

173. Cleanliness was also a recurrent issue in A&E. One family told me about their observations of both A&E and Ward 6 in 2006:

A1: [Ward 6] *was dirty. It wasn't clean. The efforts were made but there was laundry trolleys everywhere. It just looked closed in.*

A2: *The A&E was disgusting.*

A1: *Had blood on the floor.*

A2: *Used plasterers, bandages all on the floor. That was every time we went to A&E not just one time.*

A1: *... Ward 6 was the one she was in mainly and that wasn't very clean at all... I cleaned under my Mum's bed and cleaned the dust from under there after the cleaner had been. My Mum said again, don't make a fuss, I do not want a fuss, I don't want to cause any trouble.*

174. I received a letter from the mother of a 23-year-old man who visited A&E twice between 2005 and 2007. She said that on both occasions A&E was *"dirty and strewn with litter. The toilets were disgusting."* While she thought A&E had improved on her second visit, on leaving the hospital on this occasion she saw a trail of blood along the downstairs corridor which was still there the next morning.

175. It appears that Cannock Hospital was not free of these problems at this time. I saw correspondence from the husband and daughter of a 94-year-old patient who was admitted for a hip operation but died after contracting *C. difficile* there. Among other complaints they made in October 2009, they wrote of faeces being left on the floor and questionable overall cleanliness.

Substandard hygiene practices

176. Many witnesses were concerned at the poor and potentially unsafe practices they observed being employed by staff.

177. One witness who was visiting her relative in 2006 was concerned about the lack of effective infection barriers between the hospital's restaurant and the nearby ward where infectious patients were being cared for:

You could just walk right the way through and out the other end and into the restaurant, which was – yes. There was a huge sign up that said "the bug stops here", which we thought was really hilarious because it wouldn't just stop at the doorway and not follow you through.

178. The same witness observed:

... the restaurant... was on the same floor. There was hand gel as you went out of the rooms into the corridors and they were more often than not empty. There was nothing in them to clean your hands. So therefore people were just walking straight out, going in, accessing the food which was all open in the restaurant... nobody challenged you at all, no. In fact one day we saw the cleaner that had been – not cleaning but looking as if she was cleaning, serving behind the [counter] *with the same clothes on. She had got the same clothes on. It was – you just think to yourself, is this real, it was worse than you see on the television in Third World countries where families are having to look at their own patients because that's what we were doing, really.*

179. The same cleaner was observed using highly undesirable cleaning practices:

She had got a cloth, like a J-cloth, and she cleaned the ledges and she went into the wards, she walked all round the ward with the same cloth, wiping everybody's table and saying hello, wiping another table and saying hello.

Came out of there, went into the toilets and lo and behold, she cleaned the toilets with the same cloth, and went off into the next bay with the same cloth in her hand. You can't believe what you saw, you really couldn't believe what you saw.

180. Another witness was worried that the drinking beaker with which she was provided was only washed when she asked, and even then not taken away and sterilised.

181. The hand gel containers were, I was told, frequently left empty.

182. I was told of a number of instances of patients affected by *C. difficile* being moved in or out of rooms and other patients being moved in without any cleaning having been done:

...the [other] *man's wife was sitting outside and they wheeled his bed out and wheeled* [our relative's] *bed in and there was no cleaning done, whatever, and that was when I rang infection control and was told it had been most definitely cleaned. But there had been no time for it to be cleaned and we cleaned it, didn't we?*

183. The same witnesses described a further similar occasion:

We were sitting outside the room and they moved a young man in, didn't they? There was a young man in there and we looked at each other and said: they haven't cleaned the room, they just put him in there, does he know that [our relative] *has got C. difficile? He wasn't anything to do with us, unfortunately... they didn't have time to clean it. We didn't see anybody cleaning it... It was almost like again* [he] *was out and someone else went straight in. I don't know where he came from, but he was only a young man and they had put our relative into this ward.*

184. Another family told me of their experience in December 2008 of their relative being moved into and out of rooms which were not cleaned between patients:

When we got in the room it was a bigger room, so I thought, that is nice. But what's this big stain on the floor? So I said to the woman: Why is your relation moving out of this room? She said: Oh, she pulled the cannula out and she bled all over the floor. That is what the big brown stain is then. So... [we] *start clearing the blood off the floor, open the bin to find in the bin it is full of big pads they use – they'd obviously wiped the blood up and thrown it in the bin so it was splattered with blood. I mean, literally there was blood everywhere in this bin. So me and Wally used all these antiseptic wipes to clean the floor up, because I thought if Ann comes in and sees this she will go absolutely spare. So we*

cleaned that room... The other person went into Mum's room, obviously they never cleaned that, but that was not our problem. We cleaned my Mum's room. It was the same thing, "There is all debris in this bin", "It will be cleaned up later when the cleaner comes"... When she came back again that was the second move... And the same thing happened. We passed this young boy along the corridor on his bed. Straight in. That was it. So nobody cleaned the rooms.

185. The same family observed another instance of poor infection control:

There was an outbreak of norovirus on Ward 1. Ward 1 and Ward 2 are connected by a double door. Through that door to your left is the isolation room that my Mum is in. Ward 1, outbreak of norovirus, handwritten note stuck on that door. "No admittance." It was totally ignored. Staff used to walk through to the linen room or to use the loo and my Mum is in this isolation room thinking, "This is some infection control." There isn't any, basically.

186. Another witness told me of her observation of staff flouting infection control standards during her stay on Ward 11:

My concern was about cross-contamination. I was concerned about it because the lady in the bed next to Mum had got MRSA, and I witnessed on more than one occasion them assisting this lady because she was unconscious, feeding her with gloves on. The lady across the bay wanted something doing with her catheter bag and the care assistant, as she was, left the lady with the MRSA still with the gloves on and went across the ward and did what she had to do with this catheter bag, and then returned to the patient with MRSA. I'm not medically trained, but to me it didn't ring right that that could happen. It just seems common sense if you are dealing with someone who has got something as serious as that wrong with them, that you need to at least wash your hands.

Relatives taking action to improve cleanliness

187. I heard many stories of relatives being worried by failures to remove dirty and used bowls and laundry, leading to unacceptable conditions. In some cases families felt compelled to take their own action about this, eating into time when they would otherwise have been supporting the patients they had come to see

188. Thus I was told of an experience in Ward 2:

Another thing that sticks in my mind is if somebody happened to have a bout of vomiting, and I know it happened with my Mum, the bowl would be left on the table. And relatives would look round and go: what do we do with this, our loved one is about to eat, what do we do with this? I remember at one point that my Mum had one as well and one of the relatives followed me and I said:... I don't know what we do with them, but we will have to take them somewhere, and we left them at the nurses' station... I said: I am sure at some point they will

come back. I've no idea where they are... There was at least two of us that were wandering around with sick bowls, thinking: I can't leave them in our relatives' rooms. Before we go home, what do we do with them?

189. A similar distressing concern was expressed by the family of a patient on Ward 10 in 2005:

They put these pads on the bed to prevent the soiling of the mattress, and like we went in on visiting times, and you walked into the room, you just could not stop in the room. The smell was appalling. So you hold your nose, you go in, you check his bed to make sure he is not lying in it, but then it became apparent that the smell was coming from one of the foot-operated metal bins that is actually in the room. And the soiled bed pads were just put in there and as a result, that was where all the smell was coming from... So I went to the desk and requested that the bin liner be changed and the soiled pads taken away. I was told by the nurse that that was the cleaner's job and they didn't come on until towards the evening. So I said: okay, give me a bin liner, I will do it. And she says: I don't know where to take the full ones, so you can't do that.

190. A young granddaughter took matters into her own hands to remove soiled sheets when she visited her grandmother in 2006:

I remember going with my daughter, who was 13, to the ward and there was a lady that she had had an accident in the bed and there was like – where they put all the dirty laundry by Mum's bed. And this nurse did no more than walk across and placed it in the bin. My 13-year-old daughter, she is mouthy, she wants best for Nan. She says: could you move it, please. And she says: I will do in a minute. She said: no, can you move it now? Will do in a minute. That minute never came, so [my daughter] *took it to the nurses' station and said: could you move it now. It was soiled. That was a 13–year-old child. It is wrong.*

Lack of information

191. Families also expressed their concern at the lack of information about what hygiene precautions should be taken and at not being offered the means to do so.

192. The wife of one patient who contracted *C. difficile* while on Ward 12 in October 2006 recounted an incident which occurred after her husband had soiled himself because of a delay in a nurse arriving to help him to the toilet: she got given the soiled sheets to take home to wash, along with his clothes:

Well, she just rolled everything up and put them in this blue bag, you see. It didn't dream on me that it was the sheets because I wasn't there, but I must have known it was, because it was only his pyjamas and his underpants that I should have had really, but I just couldn't wait to get out, to be honest.

193. She also told me she had received no advice about washing her hands or other simple precautions, although she did take them.

194. The same point was made by another witness:

> *There was a gel thing on the locker, but nobody told me what it was for and when I had got to use it. I myself thought, well, everybody puts this gel on their hands to come into the ward, this must be something serious, and I started using it and then I did ask, oh, yes, you should use that every time – but nobody explained that until I asked, which was a couple of days I had been in there then.*

195. On Ward 11 in 2008 another patient's wife was misinformed about the effectiveness of alcohol gels in preventing the spread of *C. difficile*; she was unjustifiably reprimanded for bringing in a soap and towel to wash her husband:

> *... an auxiliary had told me to wash* [my husband]*'s hands after he had been on the commode, and I looked round for a bowl and a towel and soap and couldn't find one. So I used some of the liquid soap by the sink, and I used paper towels and I washed his hands. Next day, I came in, I brought in a towel with his name on it, embroidered on it, soap, to wash him with and* [the ward sister]*, she was in charge of the ward that day, she came and told me off for bringing it and she said: why are you bringing in soap and a towel; we don't need that, we have got alcohol gel. And I said: because* C. difficile *doesn't respond to alcohol gel, it only responds to hand washing; and she was very short with me. So I took the things back with me as I was requested to do so, immediately went online to the National Health Service's own patient advice website, at which it says to hand wash and* C. difficile *isn't responsive to alcohol gel. So I was very upset about that, that I had been made to feel in the wrong and that the person in charge of the ward was apparently not apprised of the latest information about C. difficile. No wonder they had a problem with it on the ward.*[21]

[21] The current NHS advice is that alcohol hand gels should be used in conjunction with washing with soap and water: *"The gel alone cannot kill the spores, so the additional use of water and detergent is essential."* (www.nhs.uk/Conditions/Clostridium-difficile/Pages/Prevention.aspx). DH's "*Clostridium difficile*: How to deal with the problem" document states: *"Contamination of hands of healthcare workers and patients by* C. difficile *is a well established route of transmission."* It also states that soap and water are more effective than alcohol gel in reducing the number *C. difficile* spores. The efficacy of alcohol rubs has been doubted: see 'Alcohol Rub, Antiseptic Wipes Inferior at Removing Clostridium Difficile', report from 47th Annual Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), *Medscape Medical News*, 21 September 2007

196. Evidence received concerning the response of the Trust to complaints about the management of hygiene and infections call into question the commitment and the knowledge of the Chief Executive in this area.

197. One witness recalled the reaction of Mr Yeates, the then Chief Executive, in July 2007 to a complaint he made about the dirty toilets:

I said to him: you know, I go to Asda and I sometimes use the toilets there and they are always clean... He said: we could not possibly keep the same standards as Asda. Well for goodness sake, it is a hospital.

198. Another patient received a letter from Mr Yeates in response to a complaint about the management of an outbreak of *C. difficile*. In this letter the Chief Executive said:

Clostridium difficile *cannot be passed from one patient to another and can be treated with medication.*

199. The witness told me that it was clear from advice on the Department of Health's website that this was not correct, as indeed has been confirmed to me by the Inquiry's specialist nursing adviser.

Comments

200. The Trust has been subject to outbreaks of norovirus and *C. difficile* as have many other hospitals from time to time. In early 2006 the rate of cases at the Trust increased significantly, suggesting an outbreak, the rate remained high throughout the year and there was further outbreak in August 2006. Outbreaks of norovirus also occurred throughout 2008–09, which led to multiple ward closures. Meticulous attention to hygiene is a prerequisite of keeping such events to a minimum. Even without such an imperative, the experiences of which the Inquiry has been told and which are described above are wholly unacceptable. It is clear from the evidence that the deficiencies of which hospital users complain have not been isolated mistakes or lapses restricted to one time or ward but have occurred throughout the period under review and in different wards. It is right to record that some wards have been praised for their cleanliness, but in others the poor standards seem to have been at best forced by under-staffing or lack of organisation or at worst tolerated.

CHAPTER 7
Privacy and dignity

201. Privacy and dignity are perhaps the most fundamental rights any patient is entitled to have respected in hospital. Some degree of invasion of privacy is inevitable if proper care is to be provided, but clearly this needs to be kept to a minimum consistent with the patient's best interests and the scope of his or her consent to treatment. All patients have a right not to be subjected to degrading treatment. Such respect is a legal requirement of the Human Rights Act 1998, but surely in any event it is part of the essence of good hospital care that all reasonably practical steps are taken to preserve patients' dignity. Many of the patients about whom I have heard died in hospital. While the dignity of a patient who survives can doubtless usually be recovered, even if the experience remains an unpleasant and distressing memory, the memory of the undignified circumstances in which their loved one died will be the last that those left behind have. It was sadly clear to me that some of those who have given evidence to me have been deeply affected by such memories from which they are unlikely to escape. Many patients about whom I have heard were confused or suffering from dementia and may have been mercifully unable to appreciate what was happening to them. However, such patients are just as entitled to respect for their dignity as those who are aware of their circumstances. Indeed, it can be argued that such vulnerable patients are entitled to greater protection: they are unable to protect themselves.

202. The 2001 *Essence of Care* guidance for benchmarks for privacy and respect defines privacy as *"freedom from intrusion"* and dignity as *"being worthy of respect"*. These are not entirely helpful definitions: the first omits any reference to the right to retain personal and confidential information as private, and the second might be thought to be circular. The 2009 consultation paper proposes to change the category to 'respect' and to introduce new definitions – *"freedom from unauthorised intrusion"* and *"quality of being worthy of respect"* – and adds a definition for 'respect': *"regard for the feelings and rights of others"*. These do little to make the terms more all-embracing.

203. The 2009 consultation paper sets out seven factors for which it defines best practice. These factors consider the attitudes and behaviour of staff – ensuring that people and carers feel that they matter all the time, that people's personal world and identity is respected, and that their care ensures their privacy and dignity and respects their modesty.

204. Many of the deficiencies in the patient experience described clearly had an impact on the patient's dignity, and these will not be repeated here, but the following are notable causes for concern:

- Patients who have not been given appropriate assistance with continence issues have been left in a condition which can only be described as degrading.
- On occasion, patients have been left inadequately dressed or in view of those passing the bedside.
- On occasion, patients were handled and moved in ways that caused pain and distress without any evidence of a sympathetic approach.
- Little effort was sometimes made to refer to patients by name, giving the impression that they were regarded as conditions and problems to be dealt with rather than individuals who needed care and attention.
- Respect for patients as individuals requires those caring for them to engage with them in the way they wish; sometimes this was not done.

205. The attitude of staff could be variable, some demonstrating a commendable recognition of the humanity of those they engaged with while others did not. The daughter of one elderly patient had experience of different wards in 2007. She identified two members of staff on Ward 7 whose care she deeply appreciated. One had arranged for a special bed to be provided in which her father was more comfortable:

... he was just on it for one part of an evening and then at night. He looked so comfortable. You wanted to weep, because at last he was in a bed where he looked comfortable as he would if he was at home.

Q: *These two nurses clearly impressed you, because you go on to say in your letter: "He spoke to him with dignity and told him what he was going to do before he did it."*

A: *Yes, he never went without having a word, and* [two other nurses] *were both the same. Before they did anything, they told* [him] *what they were going to do so that – it put him in the picture and gave him some dignity, you know? Not to be treated just like, well, a log of wood...*

206. Unfortunately this was not their experience on Ward 10:

As I have said, from the simplest thing to the most important, keeping him out of pain was priority. It had got to be; it was to us but it wasn't to them. It didn't matter if he had been lying there in hours of pain, as long as... In other words, on Ward 10 the patients revolved round the staff. If it was inconvenient for staff, it wasn't done. People could be calling for a bedpan or help to get to the toilet: yes, I will be back in a minute. Off they go and they weren't back in a minute. They

had no intention of doing it, until people were just left to do it where they were. There was no dignity. There was no care. It was just totally dreadful... the nurses never spoke. They didn't know how to behave socially, I don't think. They spoke to one another though, having said that. They would carry on conversations over your head but they would never once acknowledge you... I sat, held his hand and wiped his face and his hands and washed his mouth... just there to comfort him and do whatever I could. But they didn't hide the fact that they didn't like me being there... They just totally ignored me. There was no niceties. There was no: good morning, Mrs [...]*, how are you? When they did anything for* [my father]*, it was never:* [...]*, I am going to do so and so; or Mr [...]; or whatever. They just treated him as if he wasn't there. As if he was just – well, as I said, a log of wood or something like that.*

207. A witness visiting her mother in Ward 11 in January 2007 described to me an incident in which staff were again very slow to help another patient who was in considerable distress:

... this poor guy in the opposite bay practically fell off his bed. He didn't fall off his bed, but that is how it looked. And this guy had got a hospital gown on, and I will never forget him, a tall elderly man. He was covered all the way down in faeces, he was showing all of his genitals, and I said to [my son]*: it is a good job your Nan can't see. I just shut the blinds... Nurses were down on the nursing station towards the bottom of the door, and this poor guy was shouting, I think it was his wife. I went and got to the nearest bed which I thought was his bed... I got this duvet and I said: come on, sweetheart, and I talked to him and got him back and sat him down on his chair, covered him over. And I pulled the blinds round and I went down to the nurses' station. I said: can somebody please come and help this poor guy? And this nurse turned round and said: who? I said in the bay opposite where my Mum is. Oh: that is Mr* [.....]*, he has lost it. I says: no, he has not lost it. I says: that man is crying for, I think it is his wife. That man is somebody's husband, he is somebody's Dad, I says, he was somebody's son. I says: now get your arse from that desk and get up there and see to that man. He is caked from head to foot in crap. I said: now get up there and wash that man down and give him some dignity. That man was left 25 minutes and no one came to that man while me and my son were on that ward and I was thoroughly disgusted. I thought a dog at a vet's would not be left like that, and this guy, he has probably fought in two World Wars, has been left.*

208. Even in death, patients could be robbed of their dignity and leave their families worried about what had happened when they were not there. One family wrote to me to tell me of their experiences when their father died on Ward 10 in October 2005, compounded by the unthinking attitude of a doctor:

We were allowed to see my father on his bed in Ward 10. My wife noticed that it seemed as if he was lying just as he had died, his head back gasping for breath. The staff had not thought to arrange him in a more natural way before allowing us to see him. Perhaps we should have queried why this had not been done. Was it perhaps because he had not been found until some time after his death, and had they been unable to move his limbs – or were they just insensitive to our feelings?

209. When the doctor arrived (after they had had to wait for an hour), she told them that his death had been inevitable because of his history of cardiac disease. The family questioned this as there had been no such history, and the doctor replied: *"I have been on duty all night. It has been a difficult night and I should be going home."* Not surprisingly, their reaction was unfavourable:

    We were amazed by her lack of concern and her obvious lack of preparation prior to seeing us.

210. A former member of staff who wrote to me described the complete lack of respect afforded to deceased patients:

    recently deceased patients would be left in a relatives viewing room before being moved to the Mortuary. On several occasions, I recall some of the deceased patients being subsequently forgotten about and, therefore, not moved to the Mortuary for several days. On one particular occasion, when I was on duty, another nurse [....] *was directing relatives of a patient currently receiving care into a room (in order to wait). Just before allowing the relatives to enter the room she discovered a deceased body which had been there for at least 24 hours (possibly 2 days) and at that time none of the staff knew who the deceased was. It took several hours to establish who the deceased patient was and to find all the appropriate paperwork...*

211. I heard of cases where patients were given information about their condition insensitively and without an appropriate degree of privacy:

    ... my wife's niece came over to stay with us. It was the first week that my father was in hospital. She actually comes from Germany, but she was absolutely shocked at the way a consultant would speak to a patient in the ward, would speak quite loudly so everybody could hear, discussing with – there was a patient across the ward – discussed openly, didn't pull the curtains round or speak in low tones.

[Patient's daughter-in-law]: *You could hear all that he was saying to the patient about what was wrong with them, whatever they had done to him. She heard it and she was utterly shocked that there was no privacy about the way the patient was treated.*

212. Respect for dignity requires patients to feel safe. Dignity is unlikely to be assured in a ward in which confused patients are able to wander around unmonitored, either for those suffering from confusion or for those who are not. A nurse who spoke to me put her feelings like this:

One of the things that I am determined to get right is the fact that we have – on average a third of our patients have dementia... For that group of patients, there is no dignity protected at all, because they are viewed by people without cognitive impairment as – somebody said to me – "a bunch of nutters". I actually find that really upsetting because to me they may not have a physical illness but they have an illness that... which results in them behaving in that way. They should be treated with the same amount of dignity that anybody is dealt with.

213. Privacy was ignored, as were the patient's wishes, in the following 2009 case I was told about by a retired medical practitioner who had previously worked at Stafford:

A friend of mine was in – admitted with a query heart attack about two and a half weeks ago, and she was in the assessment ward for a day and a half. She was in a mixed bay and in the bay there were two men who – elderly men who were confused and catheterised and wandering around, and one kept taking his trousers off and when she pulled her curtains round her bed a nurse said... came and pulled them back and said: why are your curtains pulled? And my friend said: well, I would like a bit of privacy, and she just sort of – according to my friend – snorted and continued pulling the curtains back.

Q: *So she left her with the curtains open?*

A: *Yes.*

214. A hostile attitude or rudeness can never be excused, but some patients and their families have experienced such behaviour, as has been seen. On further striking example was suffered by a devout Christian:

I was particularly upset one morning. This particular nurse was on the morning staff, a male nurse, and he upset me so much because he – I don't know what he said, but he had a laugh about the palm cross at the front of my Bible, and there were two of them, as far as I can recall, two other nurses there. I don't know what he said, but it was most upsetting and I didn't say anything because of reprisals... he said something about starting a fire.

215. Unhappily this particular type of behaviour appeared to be typical of this healthcare support worker. The same witness told me:

On one occasion, soon after I was in Ward 11, I was vomiting horrible black liquid and again in the morning, because I only saw him in the morning, I vomited and he just said to one of the nurses on my right, he said: oh, he has been sick. It was his manner, his attitude.

216. Patients have a right to be recognised as individuals and dealt with as such. As one nurse told me:

I was trained to – basically it is not a condition, a patient isn't there, it is not a condition, it is not a bed number. That patient is a patient; it is a person and this person needs different things. Basic nursing care, psychological care. They are not there because they want to be there.

217. This very proper view was not universally reflected in practice.

218. I was told of one patient who did not wish to be known by his given first name but by a name he preferred. Despite this, and in spite of the preferred name appearing sporadically in the records, I was told that staff persisted in calling him by his given name, causing him and his family quite unnecessary distress.

219. Another patient who *"hated"* her given name was persistently called by that name rather than by the preferred name by which she was known to everyone:

I told them on the day my Mum was admitted, when I heard the nurse call her [...], *I said: would you please call her* [...]. *She has always hated the damn name. She has always been known as* [...]. *I asked them if they could put it on her bed, but they said because of confidentiality, they could not put her name above her bed. So I asked it to go on her care plan, but we never had any.*

220. Another witness, a strikingly fit and alert 90-year-old retired nurse, told me how, on Ward 10 in February 2008, she had difficulty persuading staff to address her as 'Mrs' as opposed to using her first name:

... as soon as I got to the ward, she said: what is your name? I said: Mrs [...]. *She said: no, your other name? I said: I am Mrs* [...]. *So she said: no, we don't write that; what is your Christian name; we will put it on the board. I said: well, I object; am I allowed to object to that? I said: you are slips of girls and I am nearly a 90-year-old woman; it is not professional. She said: well, that's what everybody else does, so she wrote 'K' on the board. But I did object, but then it got worse because if they were in the ward and wanted some help, they would stand at the door and shout: Brenda, or Joyce, can you give me a hand? I thought*

that was awful. We were brought up to say Sister, Staff, Nurse. You never spoke about your personal names. I thought that was awful.

Comments

221. While I have given some specific examples of poor standards giving rise to dignity issues, almost every case I quote of complaints about basic care is one in which the dignity of the patient has been compromised. It is difficult to imagine that in any such case those actually providing the care would have been content to be the recipient of such care themselves or to have seen a relative of their own treated in such a manner. However difficult the circumstances, there is really no excuse for hospital staff, at whatever level of seniority or skill, not respecting the dignity of patients.

222. I suggest that the following not very original but easy-to-apply principles should be followed:

- All patients are individuals with their own backgrounds, needs, interests and wishes for which they are entitled to recognition and respect.
- No patient should ever be referred to by a name other than that which he or she wishes to be called.
- Staff should be readily identifiable by name and grade.
- If for whatever reason a patient has received less than acceptable care, every effort must be made to recognise the effects on the patient, remedy them, and explain to the patient the reason for what has happened.
- Sensitive information, particularly concerning diagnosis and prognosis, must be given to patients in privacy, and in earshot only of those people the patient agrees to being present.
- The patient's right to physical privacy should be respected wherever possible, and in no circumstances should a patient be left in an undressed state visible to those passing by the bed.

CHAPTER 8

Record keeping

223. Accurate and thorough record keeping is an essential part of the care to be provided to any patient. Without it appropriate plans cannot be made or followed through, changes in condition cannot be monitored, and continuity of care is prejudiced. There is no one system of note keeping and it would be wrong to criticise any hospital for adopting one system rather than another.

224. The Inquiry has had occasion to examine the medical records of a wide range of patients. Where the Inquiry had received contact in relation to a case for which the Independent Case Note Review had possession of the relevant records, these were disclosed to the Inquiry where the appropriate consent had been obtained. In some other cases the records were sought direct from the Trust. In most cases about which oral evidence was received, the records were available.

225. Regardless of the date of the case in question, a number of deficiencies in note-keeping practice were observed too frequently to be attributable to isolated poor practice on the part of individuals. These included:

- no clear registration of a patient's transfer from one ward to another;
- no consistent use of care plans;
- incomplete nursing records, in particular not following through identified problems;
- lack of consistent nutrition and fluid charts where patients had special needs in this respect;
- little by way of background information about patients, e.g. social history, history of condition etc., other than brief admission clerking notes;
- author of record not clearly identified;
- failure to record modified early warning score (MEWS) scores;
- lack of recording of discussion with patient and/or patient's family; and
- inaccurate recording of the time of a patient's death.

226. The Trust has provided pro forma record packs to record observations for different care pathways. These appear to have been used inconsistently, and certainly without all relevant parts being completed. Thus risk scores were not always entered even though relevant medication, hydration and other charts were not filled in and there would not always be nursing entries for every day of a patient's stay.

227. Many relatives of patients told me of their experiences arising out of poor record keeping. One patient told me of certain drugs that had not been given to her husband even though they were recorded on the medication chart:

It wasn't given. I don't know whether that is recorded because that was when we were at the inquest.

Q: *Do you know on how many occasions it wasn't given?*

A: *He never had it at all. He never had morphine at all. He was just given paracetamol and taking the tramadol.*

Q: *So looking at those entries, you would be concerned about their accuracy?*

A: *Definitely. They are saying again about the artificial tears. I asked them for them and they said, yes, they would get them prescribed. I went up to the chemist up the road and I got them myself because I knew what she had, and he never got them.*

228. The daughter of another patient told me that the notes recorded that her mother was not deaf on the right side as recorded in her notes but on the left. Another family was positive that they were available to be present at the consenting process required for a procedure even though the consent form recorded them as being *"not available"*. At the very least, insufficient effort must have been made to find them.

229. The family of an elderly female patient on the EAU in April 2008 were adamant that her notes were an inaccurate record of what she had consumed and how often she was assisted in washing. They also noticed in the records an entry suggesting she had moved from her bed to a chair, but were told by a nearby patient that she had not been out of bed at all.

230. A number of families pointed out to me that the time of death of their relative did not appear to have been recorded. For example, one family whose mother received care at Stafford in 2006 found that the staff could not tell them the time of their mother's death, causing them great distress. Another family whose late relative received treatment at Stafford Hospital in September 2006 and again in May 2007 had similar concerns:

... the nursing staff... said: "unfortunately your Mum has just passed away... We sat with her, we were holding her hand, she wasn't on her own." Then I went in and sat until my brother and my dad got there some time later. I was there when she was pronounced dead, when the doctor came in at that time at 3.50. But from 10 o'clock until 3.35am there seems to be no actual time of death. And I said at the time: can you tell me what time my Mum died? And they couldn't. My fear is that she was actually dead and they went in and found her. Because

I think if somebody had sat holding her hands I think it would have said in the notes: sat with and she passed away at. There is nothing there.

231. One family were so frustrated at the inability of the staff to remember to call their relative by her preferred name that her daughter took to writing it in the notes herself.

232. Another family also took to recording food and fluid intake because the staff were not doing this:

If you look at Mum's fluid charts and what she had been eating, all of those were filled in by the family. There isn't one entry on there that was filled in by any of the nursing staff. We filled those in ourselves because we were sort of managing Mum's food and fluids.

233. As is apparent from the last two accounts that patients' records were often left where they were accessible to others. This could lead to a breach of confidentiality:

One thing I can remember, and having conversations with other people's relatives as well, when my Mum was in the isolation ward, her notes were constantly left outside of the room on the relatives' chairs, and I would constantly walk into the ward to see other relatives flicking through my Mum's notes and saying: what is this then. And I thought, that is really good data protection, that is. I would say: excuse me, that is my Mum's notes; and I would put them at the end of the bed. Obviously for quick – and efficiency, if somebody is doing a round, they want it outside, but it doesn't take two minutes to put that back in the actual room where it needs to be in.

Comments

234. It is not necessary to burden this report with more examples of these deficiencies and it is possible in some, but by no means all, cases that the records have been lost or missorted, either because parts of a record have become separated on the ward or in the course of the numerous inquiries and investigations to which some cases have been subject. However, I consider that a review of note keeping should be undertaken.

CHAPTER 9

Diagnosis and treatment

235. Misdiagnosis by medical and nursing staff was a concern raised by a number of families who told me about the profound impact it had on their relative and all those concerned. Families also expressed frustration with delays in diagnosis and the consequent delay in treatment. The majority of cases where diagnosis was an issue, however, related to the way in which families and patients were engaged or involved in the process. In some cases, medical and nursing staff failed to listen to those who had useful information about the patient's history and symptoms, which would have contributed to the diagnostic process. In other cases, the diagnosis and prognosis was given to patients without sensitivity or compassion. While I recognise it would be inappropriate to speculate about diagnosis before the appropriate tests are conducted, it is evident that families felt that they were not provided with the opportunity to discuss their relative's case at any point or that they were not kept up to date.

Lack of proper observation of patients and misdiagnosis

236. I heard a number of cases of clear misdiagnosis, which give cause for concern about the standard of care being applied. While it is for the Independent Case Note Review to determine the extent to which such concerns are justified on the basis of an expert examination of the records, some of these cases are relevant to an examination of what systemic lessons are to be learned.

237. I heard a tragic story of a healthy 20-year-old male who was involved in an accident on his bike and was subsequently taken to Stafford Hospital. He received minimal observation, did not undergo a thorough examination at the A&E department and was discharged with a diagnosis of bruised ribs. However, medical staff had failed to identify a ruptured spleen, and he died a short time after leaving hospital.

    The only time he was seen was at the very beginning, a chest X-ray, and then he was just left on his own. But surely if an ambulance report twice is ticked, life threatening if not treated, surely they should have observed him. Surely someone somewhere along the line should have kept checking on him and surely the fact that John was fit, was healthy, looked fit, looked healthy, and the state that he was in surely that should have rang alarm bells.

238. An A&E consultant who was not personally involved in the case considers that this was an avoidable death, and he wrote a report to that effect when asked to do so by the Trust's legal adviser in preparation for the inquest. What happened to that report will be considered in the section on complaints and incidents.

239. The mother of a 14-year-old boy who broke his wrist playing rugby told me of her concerns about the care her son received in A&E at Stafford Hospital in March 2009. Following the accident, a fracture to her son's wrist was diagnosed and realigned at New Cross Hospital in Wolverhampton, however the family decided to go to their local hospital (Stafford) to have a plaster cast fitted. Although doctors within A&E sent her son to the fracture clinic for a cast, because of swelling, no cast was put on his wrist, and the boy returned home with blocks in place to keep his wrist aligned.

240. His mother told to me how, later on that night, her son was screaming with pain, and so the family took him back to Stafford A&E. There a doctor assessed him, but no further X-ray was taken, and the boy was told by medical staff that he had just "*caught it*" [the wrist] and was sent home with painkillers. Unhappy about the care he had received, his mother decided to contact New Cross Hospital so that her son could get the cast applied there, and was given an appointment for the following morning with the orthopaedic consultant. His mother described to me what happened then:

    We took him to Wolverhampton, and the orthopaedic consultant said that there was no option at all, but he had got to have it plated, because it had come out of line so much that it couldn't be successfully re-aligned now. And they actually operated that afternoon, early afternoon.

241. She also described the impact that this has had on her son's life:

    But the impact on him as a person is phenomenal. I mean we are talking about sort of somebody who I accept with a broken arm couldn't have played cricket at the beginning of the season, but hasn't been able to play at all because he can't actually get the movement within his wrist. He knows he probably won't ever be able to play cricket again. He knows he is not going to play rugby again. He can't take that risk. For someone who is a sportsperson, [sports] *are fundamental to their lives.*

242. The daughter-in-law of woman born in 1927 told me her mother was wrongly diagnosed with cancer in 2004 and given six months to live. In September 2007, the treating physician wrote a letter to her mother-in-law's GP stating that the diagnosis of oesophageal cancer was doubtful. He wrote a further letter in July 2008 stating that the disease must have been benign. Despite this, her mother-in-law was treated for terminal cancer until November 2008. She vividly described the impact on her family:

It just seemed... we had all got a black cloud over us. Waking up every day, is this going to be her last day. We were called twice down to her, they said she wouldn't last overnight, and thinking, every time the phone rings, is this to say Mum has gone, you know. It was one of the hardest things that we have ever had to go through, you know.

243. I received many letters from patients and families who had concerns about misdiagnosis of their condition at Stafford Hospital. The wife of a 52-year-old man wrote to me about her husband's experience in A&E in April 2005. She explained that he was suffering from severe abdominal pain and that he was seen by a junior doctor who, after a urine test, insisted that he had a urine infection. Her husband was not satisfied with this diagnosis and suggested that he could be suffering from appendicitis. He was told this was *"impossible as he was too old"* and was discharged with antibiotics.

244. The following day he collapsed, and an ambulance was called. He was seen quickly, and the doctor suspected peritonitis as a result of a burst appendix. No records could be found in relation to her husband's presentation the previous day.

245. I received another letter from a man whose father attended A&E in January 2006:

[My father] *attended A&E in the early hours of one morning with chest pain, seen and discharged by a junior doctor at that time having been issued with antacid, he again attended A&E with chest pain in the early hours of the next morning this time suffering a fatal heart attack.*

246. His father's A&E notes were subsequently reviewed by a consultant at the hospital on the request of the Patient Advice and Liaison Service (PALS) team. The consultant noted that the patient's history, clinical examination and investigations led the treating physician to make a diagnosis of gastritis. On reviewing the investigations, the consultant noted that although the relevant blood tests were all normal, the chest X-ray and ECG showed changes that warranted a further specialist opinion. No specialist opinion was sought.

Delays in diagnosis

247. A number of families told me that there was a significant delay in arriving at a diagnosis about their relative's condition. This delay did not appear to be isolated to one particular department: I heard of concerns regarding delayed diagnosis in the outpatient's department, Ward 11 and the emergency assessment unit (EAU). In addition, I heard from families who were never given a diagnosis even after the death of their relative. Some families have only learned what contributed to their relative's death through an autopsy or an independent case review.

248. I heard from the husband of a 54-year-old woman who was under the care of a consultant at Stafford Hospital for exploration of abdominal pain during 2008 and 2009. He told me that on one occasion on Ward 11 in September 2008, when his wife first went in for treatment, her scan results were misplaced, which led to a delay in the findings being reported to his wife and her family.

There seemed to be some confusion about her diagnosis. I think she had a CT scan at the same time as well, and the CT scan results were or had gone missing and they were slow on being produced... And there was some delay on giving some diagnosis from the consultant at the time.

249. He went on to tell me that he raised the question of his wife's diagnosis with nursing staff as there continued to be confusion over the diagnosis.

Q: *On the ward, in October and November, did you have any dealings then with the nursing staff, can you remember?*

A: *Only to question the diagnosis, because there was still some confusion over the diagnosis, whether it was actually pancreatitis. It went from acute to chronic to recurrent chronic back to acute pancreatitis. Why it should be recurrent, I don't know, because it never went away in the first place. Recurrent says to me it is happening again but it never went away in the first place to happen again.*

250. The same patient was eventually diagnosed in March 2009 with cancer of the pancreas with metastasis to the liver after experiencing further severe pain in 2009. The family felt that this could have been detected earlier by the treating consultant and that the diagnostic process was only accelerated when a complaint was made.

... within 24 hours (of making the complaint) she was diagnosed with cancer... She was seen on the Friday and [the second consultant] *called me to the hospital for a meeting with him... and he said then that he strongly suspected that it was pancreatic cancer. He needed to carry out a further CT scan and a liver biopsy to confirm his suspicions, and that happened the following day and we had the results by the end of the week. From my perspective and my wife's perspective, everything seemed to be accelerated in that one-week period. We found out more than we did in the last – previous six months. What amazes even more than anything else, how come* [the second consultant] *had come to such an amazingly fast diagnosis, whereas* [the first consultant] *hadn't spotted this in six months? It just doesn't seem right.*

251. The daughter of an 82-year-old woman told me about the delay she experienced in receiving the results of her mother's urgent scan when she was a patient in 2006:

She went for a scan on her back and she had to go to Cannock, I believe, for this scan... It was nearly two weeks before the scan come back. It is supposed to be an urgent scan. It was nearly two weeks or something before – they would not give us an answer for this scan... We never knew what was going on. We never knew what was the matter with [my mother]*. All we knew is she was getting worse the longer she was in there.*

252. She went on to tell me that the longer it took to reach a diagnosis, the more her mother's condition deteriorated.

The longer she was in there, the worse she got, to be honest with you, and I do not think being in hospital made her condition any better either. She would have been far better if they would have let her come home, we could have done exactly what they were doing in the hospital, and she would have been a lot happier. It was distressing to go to see her, to be honest, because she was in such a bad state. All she wanted to do was be told what was the matter with her, which they never did, and come home as soon as she could.

Families not listened to

253. I heard many cases where patients and families had information about their relatives but they were not listened to during the diagnostic process, which may have in turn hampered diagnosis and delayed treatment. Carers of patients should not be ignored; they often have a depth of knowledge of their loved one's condition that is far greater than what staff can obtain on a brief acquaintance.

254. The daughter of an 86-year-old woman told me that while her mother was a patient in the EAU in 2007, it was obvious to her that she had a chest infection. However, despite continually raising this, it was ignored by staff:

Mum clearly had a chest infection and it just seemed to be that there was so many junior doctors in and out of the room that it was really difficult, particularly for Mum who was hard of hearing, to keep repeating what was wrong with her and to get any formal diagnosis. One of the problems was she had gone in because of a swallowing [difficulty]*... and the chest infection was really an added problem for the doctors to diagnose, but they didn't seem to want to listen to the very basic things like Mum was coughing up, you know, sputum.*

255. The family of another elderly woman, who was a patient at Stafford Hospital in 2006, was told that it was her chest that was causing her discomfort, but the patient and her family repeatedly reported that the pain was also in her back:

They virtually ignored us every time we said about her back, and they could see that she was trying to hold her back, they still seemed to ignore the fact that it was her back... Even in the wards, when she was transferred to the wards, we kept saying it is her back and they kept saying it is her chest.

256. This witness went on to tell me that, as she had experienced her mother suffering with chest infections on numerous occasions, she was able to detect these early on and was therefore able to prevent them from becoming too serious. However, while her mother was in Stafford Hospital the staff failed to listen to her again when she detected the onset of a chest infection:

The staff were also made aware that when [her mother] *started having one of her chest infections, they normally came on rapidly and action had to be taken quickly to stop it getting out of control. One day the staff were told that an attack was coming on and nothing was done about it for about 48 hours. Consequently she had to suffer even more distress.*

Lack of diagnostic follow-up

257. Sometimes constant changes in staff and a lack of communication between them meant that diagnostic questions were not followed up. The son and daughter-in-law of a 90-year-old woman who was a patient on Ward 8 in 2008 told me that they continually raised questions about a possible diagnosis, but were ignored:

[The patient's] *GP rang me to explain how he had gone to visit her and what he had found, and what he had sent her in with, and he said that he had put a query stroke for the hospital. He said: has anybody mentioned mini-strokes? And I said: no, they haven't. So this was the reason that... we kept mentioning in Ward 8, what about strokes? Has anybody examined her or – for this? Do you think this is the reason behind her state at the moment? It was noted by a member of staff and [said] she would look into it and then we would go – and then the following night ask, and we would either see a different member of staff, or we would find it hadn't been passed on. In fact, it was never acted upon until she went into Ward 10, as far as we know.*

258. The husband of a 54-year-old woman who was under investigation for an ongoing abdominal complaint in 2008 told me that he felt the consultant's judgement was restricted by a presumption he had made about the patient:

... on each and every occasion [the consultant] *had seen my wife, he went through this process of asking about her drinking habits. My wife never had more than three pints a week. In fact, she probably had two or three units a fortnight. She hasn't been a drinker and she hadn't drunk to any excess since she fell pregnant... which was back in 1977/1978... personally I feel that this*

may have clouded [the consultant's] *judgement, that he was searching for a chronic alcoholic, given that pancreatitis, I believe, is more common in chronic alcoholics... at the end of the session he said into his dictaphone: "This lady still insists that she doesn't drink." In quite a nasty tone, a sarcastic tone maybe... I firmly believe that... he allowed this to cloud his judgement on the diagnosis of cancer.*

259. While scepticism at denials of this nature is sometimes justified, it is suggested that diagnostic considerations must encompass at least the possibility that the explanation for the symptoms lay in something consistent with the history being given.

260. The daughter of an 82-year-old woman complained that in spite of her continual assertion that her mother was in pain, she was ignored and no further investigations were undertaken to establish the root of the problem:

If they had said to us: look, it is quite possible it is the stent causing that problem; or it is quite possible we have nicked you, let's go and X-ray you and have a look. But they didn't. They just kept saying: it will settle down, it will settle down. But from 28 August to 14 January 2009 when she died, she was in pain all that time, despite seeing doctors, despite me jumping up and down saying: she is in pain, can you not do something?

261. The very least that worried relatives – and the patient – are entitled to is a reasoned explanation for why it is considered that the cause of pain is other than what they suspect, and for action to be taken to remedy a distressing symptom.

The way in which diagnosis was communicated to patients

262. I heard from a number of patients and their families that they were unhappy with the way their diagnosis and prognosis was communicated to them. Primarily, families told me that they do not think that patients should be given bad news when they are by themselves with no family there to support them or to fully absorb the information. Some examples of this are included in the section on communication but others are more appropriately considered here.

263. The wife of a 64-year-old man accompanied him to an outpatient appointment in 2007 with a consultant who took an apparently cavalier and casual approach to a very serious situation. It appears that he only read a vital biopsy report as the couple were leaving:

We went in to see [the consultant]*, we were both sitting together and* [the consultant] *facing us and he just turned round and he says: yes, you are high risk for polyps, aren't you; of course you do know they could turn cancerous?*

We said: yes. In that case, he says, we will see you in May 2008. And it wasn't until we got up – we were at the door when he says that puts a different light on the issue, you have got cancer. So to me he hadn't even read the biopsy reports properly.

... He never even turned round and said: I am sorry, or even called us back from the door to sit down again. We had got the door open and we were walking out thinking: we are so relieved, he has gone five years and there is no cancer, he had got away with it, thank God for that. It was when we opened the door, he said: that puts a different light on things, you have got cancer.

264. I heard from the daughter of a 54-year-old woman who was diagnosed with cancer but not immediately informed of that diagnosis. She recalled that her mother was visited by a Macmillan nurse before she was aware that she had cancer. Furthermore, she was unhappy that her mother was told of her diagnosis when she was alone, without her family there to support her.

Long waits for assessment and diagnosis

265. A common complaint expressed particularly by those who wrote to me concerned the waits they or their relatives experienced for assessment, diagnosis of their condition or treatment, particularly in terms of obtaining relief for their pain.

266. Patients recalled the anxiety caused by excessive waits in the A&E department. I received a letter from the wife of a man who was being treated for bowel cancer. In October 2007 her husband had a high temperature and was suffering with sickness and diarrhoea. His GP sent him to A&E. His wife had been instructed by the GP to inform staff of his condition to reduce the risk of being exposed to further infections. She told staff on three occasions, but the couple were told to sit and wait. He remained waiting for seven hours before being transferred to the EAU. In January 2008 her husband had cause to attend A&E again as he was suffering from jaundice. He arrived at A&E at 5.30pm. He was still there nine hours later, at which point a nurse told the couple to go home because no bed could be found for him.

267. The husband of a 53-year-old woman wrote to me to tell me of his wife's experience of arriving at A&E. Her referral note from her GP could not be found, and his wife was then left to wait on a trolley for five and a half hours before being transferred to the EAU.

268. Some patients reflected that delays in assessment of their condition were linked to the chaotic environment they observed within A&E, and specifically to the lack of effective triage. I received a letter from a woman who was taken to Stafford Hospital with a broken wrist. She recalled that she had to wait over four hours before being assessed. She went on to say:

I know they see patients in order of need but people kept coming and going and it seemed to me that the receptionist was doing the assessing. I went and stood waiting in front of her to ask about waiting times and she refused to lift her head to acknowledge my presence for several minutes – this was after two hours. She was very unfriendly and I felt upset but said nothing.

Comments

269. Mistakes in diagnosis are sometimes inevitable, however clear matters may be with hindsight. Whether or not they are avoidable, they are always likely to be detrimental to the patient, and knowledge of the mistake will add to the distress suffered, particularly when the missed diagnosis is of a life-limiting or other serious condition. However, some of the errors of which I was told appear to echo rather wider concerns about some areas of clinical service at the hospital, which will be considered in greater detail in relation to governance arrangements.

CHAPTER 10
Communication

270. Admission to and treatment in hospital is almost invariably a time of great anxiety, not only for the patient but also for those closest to him or her. Patients and those closest to them naturally require to be kept informed of developments and will be worried if they are denied this or if they have to make great efforts to find out what they want to know. It is of the very essence of modern medical care that it is provided in partnership with the patient and always subject to the consent of the patient or authorised representative, following the provision of the information needed to make decisions. This requires a continual professional conversation with the patient and those authorised by him or her to receive treatment information, so that those involved are thoroughly informed of the current position and enabled to play their full part in the process. Communication in a hospital setting is not a one-way process. It is as vital that patients and their relatives are listened to – for in many ways they are the experts on the patient and his or her needs – as it is for hospital staff to provide information.

271. Communication with patients and those closest to them requires staff to have ready access to the relevant information, and the time to impart it. This requires good record-keeping, proper handovers and a caring attitude, promoting the easy recall of particular patients and their problems. Provision of information should not be treated as a nuisance to be fitted in when convenient to staff. It is an intrinsic and vital part of the process of treatment. Patients are entitled to information enabling them to judge the progress of their treatment and to make relevant decisions about it. Those closest to them may be able to assist in the assessment of the best interests of those who cannot make decisions for themselves. Treatment and care are matters in which the patient should be involved in partnership, along with those that he or she agrees to be involved.

272. The 2009 *Essence of Care* consultation paper suggests a number of best-practice benchmarks for communication. Unsurprisingly, these include: ensuring that communication takes place in an environment that is acceptable to all parties; that staff have effective interpersonal skills; that communication needs are assessed and information effectively shared. However, the paper also points to the need to ensure that patients and carers are empowered to fulfil their role in supporting patients.

273. A very significant number of witnesses gave me accounts indicating that communication with them and the patients fell short of these standards. This has left those most motivated to protect the patients' interests often unaware of what has happened, even when serious, untoward incidents have occurred, and on one occasion of what was proposed, even where that involved an operation on a patient incapable of giving her own consent. Great difficulty could be experienced

in obtaining the most essential information about current diagnosis and plans for treatment. However, the requirements of communication can be at a more mundane level. It is surely a natural human reaction to ask a patient how they are feeling, yet one patient could only recall a cleaner asking her how she was on a regular basis. The manner of staff in giving or receiving information also left a lot to be desired, according to the evidence I have heard. Some found a lack of compassion in the way bad news was conveyed, others felt that they were considered to be a nuisance for trying to find out things. Yet others found that one part of the hospital system seemed unable to find out what was happening elsewhere, even to the extent of not knowing where a patient was to be found. Such deficiencies can be detrimental to the well-being of the patient, who will quickly lose confidence in the ability of staff to provide correct treatment if they do not have the right information. Furthermore sometimes staff are in danger of acting on wrong or inadequate information. I shall now give examples of what I heard relating to communication, grouping them in themes that have emerged. Other examples appear in my consideration of diagnosis, treatment and care management.

Lack of compassion for patients or lack of reassurance that staff care about individuals

274. Being in hospital can be a lonely experience. The simple reassurance that some other human being cares about the patient, and identifies with what he or she is going through, is tremendously important. The relative of one patient remarked:

It was lack of anything; compassion; nobody ever came in to see Mum and just say: how are you [name]*? Which my Mum used to love. That was the whole thing about the home, they would call her by her name. She loved it. She liked a bit of fuss actually, if I am honest. But no, no compassion whatsoever.*

275. Such compassion can be shown by any member of staff: it merely requires thoughtfulness and recognition of the human needs of others, qualities which surely every member of a hospital's staff should share.

276. One elderly but very lively patient who was a retired nurse herself told me:

[A member of the nursing staff] *who was in training doing the university course, I think, and she was doing a little spell on the ward, and on my first day she came and sat and chatted to me and talked about my experiences and my problem, and I enjoyed that, but that was the only time while I was in there that anybody came and talked to me.*

277. Another patient's relatives told me:

[Daughter 1]: *We had more compassion from the cleaner.*

[Daughter 2]: *Yes, she was wonderful. She found us a fan because he was so hot; she found us pillows, didn't she, when his own had been pinched. She found him a little white – one of those cotton blankets. Just to put over him. She was wonderful. We said to her, we were both together, and I said to her: you know, they ought to be doing the cleaning and you ought to be doing their job because you have more compassion in your one little finger than there is in the whole – in the rest. And that was true, it really was.*

278. I heard from a 72-year-old woman who recalled that the only person who asked her how she was feeling and showed genuine delight at her improvement was the cleaner, in contrast to the nursing staff:

She came every day: morning, love, how are you? She genuinely wanted to know. I would say okay, and one night I had wakened up and found I could wiggle my toes, and it was such a delight that sensation was returning to my foot. So when she came, I said I could wiggle my toes. And she said: I bet your daughter is thrilled about that. And the next day she said had I told her. I said yes. She said: is she pleased. I said yes. She said: I bet she is pleased. And I said: yes, you, me and my daughter, we are pleased but nobody else. I did tell whatever nurse came to give me my medication in the morning, and I said I could wriggle my toes and it was... there is your medicine and off she went, no comments. That was the pattern generally of my state in hospital, that I got worse and then better with no professional input into the situation from the nursing staff.

Lack of information about a patient's care or condition

279. Patients and their families have a constant need for information about their diagnosis, what treatment is planned, and what the expectations are. They need accurate information conveyed in a sensitive fashion by someone who is well informed and capable of dealing with their questions. Absence of this, particularly where it has been promised, is not only frustrating, and sometimes inconvenient as it prevents necessary arrangements being made, but it also inevitably increases the anxiety of all concerned. I have heard from families who were not made aware of the diagnosis or prognosis of a relative and the frustration they experienced when they tried to get access to a medical professional in order to find out what the treatment plan was for their relative. I have been told that when they did manage to speak to a doctor it was often not the one involved in the care of their relative and therefore was not able to provide them with useful information. I have also heard about the inconsistency of information shared with families and instances where different family members were told different things by different members of staff.

280. The same 72-year-old woman who described her relationship with the cleaner also explained how she was admitted to Ward 11 in 2008 with paralysis in one leg. She and her daughter felt that her condition had deteriorated since her admission to Stafford Hospital. They told me that they were not given any indication about what might be causing the paralysis or what they were testing for.

Q: *... as the days passed, were you kept informed as to what was happening with your care? Were you told anything about a care plan or a plan of action to get you right?*

A: *No care plan, no explanation. I got an explanation after I had had the diagnostic CT scans and the MRI... but until that I didn't know where I was going. I didn't know what I was going for or what they were looking for.*

281. I heard from the wife of a patient in Stafford Hospital in 2008. She told me about the response she received from a nurse on Ward 10 when she demanded to speak with a doctor, having not received any information regarding her husband's diagnosis or treatment.

Q: *How often were you asking nurses or... to make an appointment or anything like that?*

A: *Daily, until this day, on the 16th, when a very, very stroppy sister threatened to have me thrown off the ward altogether because I was being very emphatic in wanting to see somebody who had information as to what was the matter. And in the end she collared a junior doctor that came in the ward – I saw him come in the door – he had never stepped foot in that ward before.*

282. I heard from the wife of a 64-year-old man who was a patient on Ward 6 in 2007. She recalled that neither nursing nor medical staff appeared to have a full understanding of her husband's condition and she did not feel that information was shared with her appropriately.

When I went in the afternoon, Miss [...] *was there again at the nurses' station and I said to her: excuse me, can you tell me how my husband is today? She just looked. She said: who is he? I said:* [husband's name]. *Oh, she says, yes, she said, he is fine. I said: what was wrong with him yesterday? She said: I don't know. She says: we are doing tests. And that was the attitude I got the whole of the way through... I never had anything explained to me whatsoever.*

283. I heard from the daughter of a 96-year-old woman who was moved to the EAU in June 2006. She told me that they were not given any explanation of why their mother was being moved and nor did any member of staff communicate with them on their arrival at the EAU.

Q: *But you didn't know why she was going to the assessment unit?*

A: *No.*

Q: *Was it explained to you or did you work out it was the assessment unit?*

A: *I knew it was the assessment unit because it was on the door, but that was all. We didn't see anybody, really. She was just wheeled in there, wasn't she, and put into the bed. We stayed quite late and they came and said: well, you may as well go home; but we didn't see a doctor then. We didn't see a doctor that night.*

Lack of involvement in decisions

284. It is clear that it is not just having information that is important to patients and families. They often have a need to feel that their concerns have been listened to and subsequently acted upon. Families recalled feeling excluded from decisions about their relatives' treatment. I heard from the daughter of an 87-year-old patient who was suffering with dementia and had an operation at the hospital in October 2007. Although the hospital informed her that her mother was due to have the operation, she did not feel as if she were involved in the decision. She did not have an opportunity to sign a form to consent to the operation on behalf of her mother, despite being available at the hospital every day. A consent form was instead signed by the health visitor and marked *"family not available"*.

285. Further examples of this appear in the consideration of the diagnosis, treatment and care management of patients.

Insensitive communication of information to patients

286. Some families felt that they should have been involved when bad news was conveyed to their relative. While some patients will want to maintain their privacy on such occasions, many will want the comfort of their family being present, and the assistance they will bring to understanding what is being said. Such consideration appears to have been lacking on occasion.

287. A number of patients and their families were dissatisfied by the way in which information – sometimes sensitive and sometimes distressing – was conveyed, apparently without consideration of the impact the information was likely to have and without any exhibition of compassion.

288. The daughter of one seriously ill patient heard how poorly her mother was in a most unacceptable fashion:

... a doctor said, oh, I need to speak to you. So he took me into the room – I was on my own at the time – and he said: I want you to sign this form. And I said: what form? He said: it's that we are not going to resuscitate your Mum;

you don't want us to resuscitate your Mum. I said: what on earth are you talking about? I think I was still in shock as well because everything was, like, ringing in my ears. I said: you what? He said: listen, your Mum, the prognosis is very poor. He said: your Mum has got – her stomach has pushed up. He said: she is going to die over the weekend and it is going to be a very painful death because what will happen is – it can happen at any moment, any second now – it can turn, it can twist and she will die You have done all you can for your Mum. Leave her with us. I said: leave her with you? He said: yes, she will be dead over the weekend, she will die over the weekend. I said: are you going to give you are painkillers? I was just totally confused what he was talking about. I said: I'm not... I said: you have already tried to kill her once. He said: that's nothing to do with us, that's the nursing staff, that's nothing to do with us. I said: look, I'm really sorry – it was like buzzing in my ears. I said: I need you to tell this in front of somebody else. So I went outside and my partner was with me. I said: will you listen to this [name], *listen to what he has got to say. And he repeated the same thing: it is going to be a painful death; we don't know if we are going to give her painkillers. That's not my decision, he said. I just couldn't believe what I was hearing.*

289. Shortly after this, another doctor came who was *"calmer"* and made it clear that no signature was required and that another doctor would come to deal with pain relief.

290. Another patient and her daughter also received alarming news from a nurse in a most insensitive manner:

[Patient]: *We were awaiting daily results now from different procedures, and one evening, when* [my daughter] *and I was together, the staff nurse was just leaving to go off duty. She popped around the curtain and she said: I have got some good news and some bad news for you; the good news is you have got no secondaries. That was from the whole-body CT scan. But the bad news is you have multiple pulmonary embolism in both lungs. She said: that's very serious. Did she say serious or dangerous?*

[Daughter]: *That's quite serious. One false move and you are out of here. And then she went.*

[Patient]: *We were just devastated really. So not only had I got thrombosis, I had got this pulmonary embolism, and I had got two brain tumours; and it seemed as if things were just going from bad to worse. So we just talked – I insisted on my daughter talking about funerals and getting my affairs in order because it was that dangerous. She told me not to get out of bed. She said don't get out of bed.*

[Daughter]: *She did make it sound like this was it, that she wasn't going to make it through the night.*

[Patient]: *That's how it came across. I don't think she meant that.*

[Daughter]: *I'm sure she didn't. But you are telling somebody who was not from a medical background, you know: you mustn't move, one false move and you're out of here; don't get out of bed, stay very still. Like Mum says, we started planning funeral arrangements, and I left that night thinking I wasn't going to see her again.*

291. Happily, as can be seen, the patient recovered. However, her daughter made another valid point about the delivery of information regarding a serious diagnosis at an earlier stage:

... when Mum was given the initial information that she had got two brain tumours... she was given this information by a doctor while she was on her own. I don't think she was in any state to receive that sort of information whilst on her own. She needed people there with her. She needed us there with her. We needed to be the ones to absorb it on her behalf because she was so poorly.

292. This view was echoed by another family:

We think that they should have alerted the family first and allowed the family to... be there... Not while she was on her own...

293. The manner in which staff communicated information could also pay insufficient regard to the patient's condition. I heard from the daughter of a patient who was partially deaf. She recalls that staff took the patient's failure to respond as indicative of her dementia as opposed to a hearing problem. Another family told me about the language used to communicate with their mother and that the nurse was patronising, referring to her mother as having been "*naughty*", affording her little dignity and respect.

294. Casual remarks can often cause distress. One patient's daughter told me:

We didn't see anyone treated as an individual. We were a commodity to be shifted through the system as quickly as possible. That is the feeling you got, observing 24/7. There is an example of that – a throw-away comment by the doctor to us: "It is amazing, they normally fade away."

295. There was often a lack of understanding of a patient's difficulties. A daughter told me of an incident where a nurse became impatient with her mother, who was suffering from cancer:

I can appreciate it is a very, very difficult job. I think if you have lost that caring element, I do not think you should be doing the job. I can give you an example: my Mum's hearing had been affected, and they told us it was the chemotherapy affected my Mum's hearing. And one day one of the nurses came in, and I was

just sitting reading next to my Mum, and she said to my Mum:... what medication have you had today? Is Mum supposed to remember that?... and my Mum had said: sorry, what did you say? And she snapped: I said, what medication did you have? I said: excuse me, I didn't understand what you said, you'd mumbled it. And she huffed and she puffed and she banged the door and she left. And I went later to find this lady and said: excuse me, don't treat my Mum like an elderly idiot. She is a 67-year-old lady who is fighting for her life. All she wants to do is get mobile and go home and be with her family. Civility costs nothing. She just walked off.

Reluctance to give information

296. There were occasions where medical and nursing staff went to great lengths to avoid having to discuss issues with families. I heard from the wife of a 68-year-old man who was informed that his condition was terminal. On seeing the consultant in the corridor, they recalled that he hid in a linen cupboard to avoid, in their view, having to discuss her husband's case further. More generally, I have heard that families were made to feel like a 'nuisance' and as though it was not their right to have such information.

297. I was told by one family of the difficulty in finding out the identity of some staff:

Then the first time we saw this particular sister – the ward manager. She invited us into her office and her first words were: where did you get my name from? She was astounded that we had been able to find out the name of a ward manager. That's a common complaint across Stafford. I don't know whether it still exists, but it is very difficult finding out who is in charge of that ward at that particular time.

Delays in giving information to patients and their families

298. I heard of too many cases in which patients had experienced some traumatic event, such as a fall causing some injury, after which the next of kin only discovered what had happened on arriving to visit. Common humanity requires the close family to be told as soon as possible of distressing events so that they can offer comfort and support.

299. The son of a previously independent 90-year-old described his horror when he arrived at the hospital to find his mother confused and distressed and then subsequently to find out she had fallen:

But on going round to the side, she said: [.....], *come round here. And when I went – as I say, my mother was lying with her head like that and I was talking face to face to her, so to speak. When I went round the back, there was a great big item of gauze with a strap of plaster crisscrossed across the back of her head. I said: oh God, what has happened? So immediately, I tried to find a nurse. After some time I did find a nurse who I said: what's happened to my mother? And she said: she fell during the night. I said: well, why haven't we been informed? I said: why hasn't anybody come to us while we are sitting at the bedside to tell us what's happened; we have not even had a phone call this morning to say that she fell in the night; what's happened? She said: I don't know but I will go and fetch a sister to speak to you. Eventually a sister came to me. I don't know who she was. I was so upset, I did not take her name.*

Failure of communication between staff

300. It is an essential part of the care of any patient that adequate information is handed over from shift to shift and between different clinical teams and departments. I heard of occasions when relatives were told that a patient had been discharged when he or she was still being treated as an inpatient. In others, the hospital social services department had not been made aware that a patient required an assessment, and a patient assessed as being at high risk of falls on one ward was transferred to another ward without that information being passed on. A considerable number of families told me that there was a lack of communication across the hospital and there was a failure to take a 'joined-up' approach to patients' care. Families also told me that they do not believe that nursing staff are undertaking a sufficient handover between shifts, as staff coming onto a shift appeared to have little knowledge of their relative or the significant events of the day.

Patients given the wrong information

301. Delivery of incorrect information can be extremely distressing and lead to a tortured re-visiting of whether a sad outcome might have been avoided had the correct information been conveyed. A particularly striking and sad case involved a woman who was mistakenly told she had been diagnosed as suffering from cancer when a Macmillan nurse was erroneously sent to her instead of to another patient. The woman had a particular fear of cancer because of a history of it in her family. This event had a terrible effect, as her husband told me:

... as part of the discharge procedure, she was waiting for her release notes, sitting on the bed, and she was visited by a palliative nurse, and this put the fear of God into her. It really did, and made her very, very distressed. I can't stress how much it made her distressed, because all her fears had come to the fore. I don't think she ever got [inaudible] *until the day she died.*

302. This feeling was subsequently compounded when, sadly, it turned out that his wife did have cancer, the diagnosis of which had been delayed.

303. I heard of another case in which the wife of a man who was taken away from home with a suspected heart attack to A&E tried to catch up with him at the hospital but he could not be found:

> *I rang up... and they said: oh, yes, it's fine, he is in a small room sitting up in bed waiting for the doctor to come. I thought: that's a bit quick but brilliant if he is. Got up there; went to the reception; told them. They said: oh, yes, sit down, we will get you to him in a minute or two. Fine. Sat there in the waiting room and waited and waited and waited... and a nurse came out... and said: will* [the patient] *come through, please. And I said: what the heck do you mean? He is through, he is in the little room, you have told me. He has got a heart problem, he started bringing blood up, he is here. She said oh, and ran off and came back and she said: no, he isn't, he isn't anywhere. I think you will find he has got fed up and he has walked home.*

304. In fact he had been taken by ambulance away from A&E to another hospital.

Failure to listen to patients and families

305. I heard from a number of families who had tried to raise concerns about their relatives' condition and felt that they had been ignored, often to the detriment of the patient.

> *I kept asking them and asking them about the swelling and I never got any answers. I was never told anything at all. I think that if they had treated him properly for the fluid on his legs, that... I think that in the end, that the water actually hit his lungs and then his heart, and that killed him.*

306. Even if there was no connection between the swelling and the patient's death, an issue under consideration by the Independent Case Note Review, his wife has been left with the torment of believing that the outcome might have been different if staff had listened to her. Such beliefs are often accompanied by feelings of guilt at not doing more, even where, as here, there is no objective justification for her to blame herself.

307. In another case, constant requests by a patient for a leg support to be replaced – it had been taken away – were ignored:

Q: *You mentioned that this temporary leg support had been provided and taken away. Did you in fact ever ask for any sort of support for your leg?*

A: *Every day. Every time a trained nurse came by me, I said: please can somebody do something about my foot? And the usual response was: yes, I will be back; and nobody came back.*

308. I have already mentioned in considering the lack of respect given to patients' dignity the reluctance of staff to call patients by a preferred name if different from their given name. Communicating with patients in the way they prefer is an easy way of reassuring them that they are being recognised as individuals with a personality and a history of life outside the hospital, and that they are not merely an official statistic.

Engagement

309. Families and friends can provide valuable support – both practical and psychological – for patients in hospital. Subject to their not hindering the provision of essential care, they can provide advocacy for patients who cannot speak for themselves, or are otherwise vulnerable, provide useful information to nursing and medical staff, and help provide basic care. While none of these can or should be expected, where they are offered they should be welcomed and accepted. Unfortunately, I was told of too many instances of families and friends being made to feel unwelcome, excluded, in the way or in breach of sometimes strictly interpreted visiting hour rules. Particularly in a hospital that was manifestly short-staffed, this was a short-sighted and counterproductive approach.

310. The wife of one patient on Ward 10 in 2008 told me:

... the nurses never spoke. They didn't know how to behave socially, I don't think. They spoke to one another though, having said that. They would carry on conversations over your head but they would never once acknowledge you. You were an absolute pain because – I used to get there at about 9.15, 9.30 every morning, and I always asked permission to go on to [the ward] *– is it convenient for me to go on to the ward to stay with* [my husband]*? I sat, held his hand and wiped his face and his hands and washed his mouth. Just there to comfort him and do whatever I could. But they didn't hide the fact that they didn't like me being there.*

Q: *In what way was that obvious to you?*

A: *They just totally ignored me. There was no niceties. There was no: good morning, Mrs* [...]*, how are you? When they did anything for* [my husband]*, it was never: Mr* [...]*, I am going to do so and so; or Mr* [...]*; or whatever. They just treated him as if he wasn't there.*

311. This was exacerbated by the tendency for ward staff not to introduce themselves, or to wear name badges or uniforms that identified them clearly to patients and families. The same witness pointed out, for example, that it was difficult to distinguish trained from untrained staff:

... if there were untrained staff, then the trained staff mingled in very well, because I never knew which were untrained and which were trained, because, as I say, there was no way that they could even pass the time of day with you and it wasn't because they were busy... but nothing was addressed to you, socially... – a "good morning" or "how are you"... Nothing at all...

312. The daughter of a 96-year-old woman who was a patient on Ward 11 in June 2006 also noticed the lack of acknowledgement from staff:

I know I am nobody and it doesn't matter, but, surely, courtesy... nobody even came and said: are you all right with your Mum? Other than this young lad walking by, I never spoke to anybody. Nobody came and said: could you do with a drink or anything? There was nothing there.

Comments

313. A well-run hospital will ensure that the staff who are caring for a patient at any time possess the relevant information that will enable them not only to carry out their duties but also to inform the patient and, where appropriate, their family of the current position and what is intended. If individual members of staff are not in possession of the relevant information, it should be possible for all reasonable inquiries to be answered authoritatively within a short time. Staff who are in contact with patients need to know sufficient information about them to be able to treat them with humanity, respect and interest. Patients need to feel valued as individuals and not merely treated as bed numbers and conditions. While this is more difficult than it was in the days when patients commonly remained in hospital – and in the same ward – for weeks, this level of involvement in the individual patient is still necessary.

314. The evidence I have heard demonstrates that this apparently simple but vital part of hospital care was not carried out as it should have been on far too many occasions.

CHAPTER 11

Discharge management

315. The pressure on a busy hospital to discharge patients is considerable. Their capacity to admit and treat new patients is obviously limited by bed capacity and it is important to ensure that only those patients who need inpatient care are kept in a bed, and that those who do not are discharged. It is in the best interests of patients that they are discharged when they are sufficiently fit to go home or be cared for in a less acute environment. However well run, hospitals are not places people wish to linger in, and there are risks, such as infection, in them doing so. Therefore, a well-ordered system of discharge management is an essential part of the hospital service.

316. There are a number of challenges to the provision of orderly discharge. While otherwise fit adults can often be discharged to go home and relied upon to make their own arrangements to do so, many others can only be released when appropriate arrangements have been made for their continuing care. This is a particular problem with vulnerable and elderly patients who require a place in a care or nursing home or who need equipment or other support in their own homes. For older patients, their discharge from a hospital can be a critical juncture, when decisions are made that may influence the rest of that person's life. A well-run hospital situated in an area in which effective social services operate and care facilities are available can be expected to have in place a system whereby post-discharge needs are identified and prospective arrangements are made in sufficient time for the discharge not to be delayed by the absence of some vital resource.

317. Unfortunately, many patients and their families (96 in total) have had cause to complain to the Inquiry about matters surrounding their discharge from the hospital. The principal matters for concern have included:

- discharge from A&E without an appropriate examination or diagnosis being concluded;
- premature discharge from wards;
- protracted process of discharge;
- failure to communicate discharge arrangements to patients and their families;
- discharge at an inappropriate time or in an inappropriate condition; and
- failure to ensure appropriate support.

Discharge from A&E

318. I heard of two very alarming incidents involving the inappropriate discharge of patients from A&E, which are described in the chapter on diagnosis and treatment.

Inappropriate discharge from wards

319. I also heard of cases where patients were discharged without a diagnosis or alleviation of the symptoms with which they had been admitted. In some cases relatives had to press for patients not to be discharged because they feared the consequences.

320. The daughter of one elderly patient told me of her reaction to her mother being discharged home still very ill, suffering from *C. difficile*, and with no support:

> *When... we got her home, she just had no energy; she was sleeping all the time, she couldn't get out of bed, she couldn't do nothing and this terrible diarrhoea, it was every hour and a half, day and night, and I have never smelt anything – I can't say it smelt like death because I do not know but I have never smelt nothing like it. It wasn't like normal excretion, it just wasn't. It was horrendous... My Mum couldn't help us. My husband was having to like ease her to it that way and then cuddle her and sort of shuffle to the commode which we had at the side of the bed and I had to like get my Mum onto there and then I would clean my Mum and then it was the shuffle again to get her back on the bed. She couldn't – she just – we didn't know what to do. I mean we were sobbing, we had nobody to talk to.*

321. The partner of a 90-year-old man told me of her reaction when told that he would be discharged as soon as his pain was under control:

> *... at the end of the seven hours they said: well, if we can cure the pain, we will discharge him; he can go home. And that was when I sort of hit the roof and said: there is only one place I want this man to go and that is upstairs and you cure him. Ten minutes later they did take him upstairs and he was admitted into a six-bedded ward.*

322. This resulted in the patient undergoing surgery for his condition.

323. The family of another patient had to press for their relative to be kept in hospital. After she had been admitted with symptoms which included blood-stained vomit, they resisted a proposal to discharge her because the cause of this had not been established; as a result she was kept as an inpatient.

Discharge process

324. I heard of cases in which the process of discharge adopted had caused distress, in particular when delays occurred between the patient being prepared to leave and the actual departure. This could involve the use of the 'discharge lounge'.

325. The son of one elderly woman told me that they experienced real difficulty in agreeing a date for his mother to be discharged into a care home. Her discharge had been cancelled on a previous occasion but the family was assured that she would be discharged that Friday at 10am. The process took its toll on the patient:

Then on the Friday, of course 10 o'clock came and went and I phoned the hospital and I got through to the discharge officer after a bit of trouble and was told that he was the person in charge of discharge, it was nothing to do with this other person, and he had got to get the medication and the doctor had got to see her and everything and so it went on throughout the day. Finally I was told the ambulance was coming at 3.00, and how naive can you be, because we raced up to the home to get there for 3 o'clock... Oh, she will be here in a minute. We put her clothes in the room and got it all ready and we sat and we waited and we waited until 7 o'clock – 7 o'clock at night she arrived, absolutely shot at, she looked. She looked dreadful and she just went downhill from there.

326. Another patient and her family were exposed to quite unnecessary anxiety and inconvenience:

... they said she could be discharged but she was on some kind of special bed... they found a new mattress and said to me they only had one in the hospital; whether that was the truth, I don't know... the nurse... wheeled her down on the bed and was so concerned about this bed that she kept saying: you will make sure that when she is put in the ambulance that we are notified that this bed is here because somebody else will take it and we won't know where it has gone and we need it. I sat with my Mum all day there, it seemed all day and it probably was... – because Mum had nothing to eat or drink and I caught a young person walking by. I said: my Mum is a diabetic and she is supposed to have something to eat. "I will go and find something." He came back and he had a shop-bought trifle like that and he went, "this is all I can find". I thought, all you can find in a hospital? And this will have to do... I sat there and I think it was about 5 o'clock when we actually got away from the hospital.

327. I also heard from the son of a woman who was 82 years old at the time of her treatment at Stafford Hospital in 2007. He told me about the day his mother was transferred to Cannock Hospital and experienced a long wait in the discharge lounge, which caused her considerable distress:

... I think she left the ward at 10 o'clock, Ward 7, and she was taken into a discharge area. I phoned later that morning and said at what time should I arrive, because they told me that she was comfortable and there was no problem, nothing of concern. I was told to go at 2 o'clock. However, I did get there a little bit earlier... and she was in the most dreadful state of distress, and that continued throughout the afternoon... I was pleading with staff in that discharge lounge area – it was a small ward of four beds – to give her some pain relief because it was just horrendous. And I was told that there were no ambulances available, and I had asked to see someone, and I was told I had to see the bed manager, and the bed manager had gone home. And eventually, you know, I really said: just please, whatever it takes, I just want to get her moved into Cannock so that she can be settled and an Ambuline ambulance was booked and she was transferred via the main entrance of Stafford, where it was a very cold evening. She was in terrible distress and we had to wait for others to be collected as well to go on the same ambulance. They did say that she should have had a specialist ambulance but this was all that was available.

328. The wife of a 80-year-old man who was discharged from Ward 7 in Stafford Hospital in February 2009 recalled the delay her husband experienced on the day of his discharge and the impact this had on his health:

... we were told that the ambulance would bring him home. It was booked for 10 o'clock and he arrived at 3.10, absolutely freezing cold, quite disorientated, hardly able to communicate... He just had his dressing gown and a cotton cellular blanket round him. It was very cold weather. It was 6 February.

329. A 75 year-old-man, who was discharged from Ward 12 in 2006, suffered a bad experience: he required oxygen to be installed at home. When his wife telephoned the hospital to say it had arrived, she was informed that her husband would be brought home by an ambulance. She then tried to contact her husband via his bedside telephone but had no reply. At about 8.00pm she telephoned reception and established that the patient had been taken down to the discharge lounge at 6.00pm and had been forgotten. Eventually, some three hours later an ambulance brought him to his home address. The ambulance could not pass the parked cars in the cul-de-sac and he had to be pushed down the road in a wheelchair dressed only in a dressing gown.

330. On another occasion the hospital was reluctant to pay for an ambulance to bring her husband home from Ward 12: she was required to get a taxi even though he could not walk without help and was in discomfort. Although it must have been obvious to staff that help would be needed to get the patient into his home, none was provided:

He had to have somebody each side of him... I had to go down and fetch a wheelchair, go back to the ward, and the nurse helped me put him in the wheelchair, and I took him down and the taxi man helped me get him out of the chair and put him in the taxi... we had to wait two and a half hours for tablets before we could go...

Q: *... How did you manage at the other end when you got home?*

A: *We are in a cul-de-sac and it is a corner house. So the taxi pulled right round, we both managed to get him out, and he fell up the gate and then a very good neighbour from the corner ran across, and he helped me get him in the house and he said: do you want me to come back,* [.....], *when he goes to bed? And I said yes, please, and my neighbour put him to bed for me.*

Q: *What was your sense at that time as to whether or not your husband was in a fit state to have been discharged?*

A: *He wasn't. He should not have come home. There is no way in this world he should have come home*

Lack of communication about changes in discharge plans

331. One patient whose expected discharge was suddenly put back because he was told he had to see another doctor first, described the impact with studied understatement:

I do not know whether you all realise, if you think you are going to go home and you find out you are not, you get a bit peeved.

332. The daughter of another patient has not got over the fact that she unwittingly spent the morning on which her father died preparing for his return home when his discharge was cancelled without her being informed because he had contracted *C. difficile*:

Well, nobody told me that, otherwise I would not have wasted my time on the following morning, the day that my father passed away, re-organising his bedroom at home. I could have been with him. That is terrible.

333. The husband of an elderly patient with dementia on Ward 7 was not informed of the time she was to be discharged to Cannock Hospital, causing him serious inconvenience:

I went straight to the bed expecting her to be there… [I found her bed was] *occupied by somebody else, and there is a man sitting there, and I am thinking: who is this; this man hasn't been to see* [my wife] *before… Then this lady in the next bed who I was acquainted with over the past weeks, she said: are you looking for* [your wife]*? I said yes. They took her to Cannock last night. I then went… and asked who had sent her out and this – I don't know if she was a matron, I should have – but in the circumstances I was that worked up, I had not got a clue who she was, quite honestly… Her manner was atrocious.*

Q: *Did she actually wag her finger at you?*

A: *Yes: "I told you yesterday… she was going to Cannock." I says: "yes, you did, but you haven't told me a time. I wouldn't be here today." So I had to catch the next bus which… and I do not get back to Cannock until 4.20 and they shut the ward at 5 o'clock. You can imagine the position I was… and I hadn't got a clue and they had never even phoned.*

334. Another patient with cancer went home in need of palliative care without her husband being given any advice about what to do if her symptoms changed, and without any adequate arrangements being made. The oncology department did not even have a record that she had been discharged:

Q: *Were you given any information at all about what to do if your wife's symptoms changed?*

A: *No, nothing at all. In fact, she had had arranged for the day before she died… the oncologist had arranged for her to start chemotherapy on the Monday… by this time she had been offered a place in the hospice. I rang to cancel an appointment for the chemotherapy and they said: don't worry, we will go and get her from the ward. According to their records she was actually in the hospital still. Which I didn't think was – it is just another failing really.*

335. A lack of adequate communication led to considerable inconvenience for the son of patient who drove from Derby to pick up his mother and take her to her home in Cannock:

A lady came and put all my things in a bag and took me into the patients' lounge… And she said: you can wait in here. And I said: did you ring my son in Derby? She said: yes. So I waited and that was 12 o'clock. At 1.30 nothing had happened, so I went out to the desk and I said: have you had a message from my son? No. Have you rung him? Oh, we will ring him. So they clearly hadn't

done it. So they rang Michael in Derby and he came up, that is a good 50 miles, and when he walked in, he said: I have come for my mother, Mrs [...]. *And they said: she has gone. He said: where? We don't know, a woman took her. That was the ward clerk, had put me in this room. So he went all the way back 12 miles to Cannock. I wasn't in the flat. He went round a few of the other flats to see if I had gone visiting. Then he rang his brother and he said: Mum is not there, where could she be? Who would take her?* [His brother] *said: Mum wouldn't do it, if she said she knew you were coming, she would wait. He said: I will ring the hospital. So* [he] *rang the hospital and they said: she is still waiting. So [my son] had to come the 12 miles up on a Friday afternoon in the teeth of the evening traffic, and then we had to go back in the teeth of it as well. And I was very upset and he was so angry. He said: how is that for communication? He really was cross.*

Inappropriate time of discharge

336. I heard of a 90-year-old woman with a history of recent hospital admissions, who was in pain and lived alone. She was discharged from A&E at 12.20am. Her son told me:

My eldest daughter and I went to the hospital and met up with her in A&E and we were made to sit outside in the reception area. We couldn't go in until the doctor had been to see... my mother, and while we were there, he told us that she was fit to be discharged and we explained... the situation and he said: no, she is perfectly fit to go home, and at that time in the morning, knowing my mother's condition, we thought she might have been kept in for observation overnight, and then a decision taken the next morning, but that was not to be and my eldest daughter and I took Mother home in our vehicle and put her to bed that evening... She was 90 years old. She had had two or three days out of hospital, living on her own, had carers coming in, yet she was sent home, you know.

337. Another 73-year-old woman was discharged from A&E at 3.30am in mid-winter: it turned out she still had a cannula in her arm. Her paramedic son told me:

I didn't think it was acceptable. She had been transferred then from the bed in the resuscitation room down to the clinical decisions unit, which I think is either a four- or a six-bedded unit. Mum was the only person in there. It wouldn't have hurt anybody to leave her in there comfortable overnight rather than sending her out in what was, as Dad said, a bitterly cold night in just a nightie and a blanket round her. I could not have physically lifted her in the car myself. Luckily, two of my friends were there, they had just brought another patient in, and they helped me to put her in the front seat of the car.

338. The patient's elderly husband described the challenges involved in getting her into their home:

So I am thinking to myself: how the hell am I going to get her out of this car when she gets here, because I had a quadruple bypass four and a half years ago and I am not supposed to lift. But having said that, what do you do?... We struggled out. [My son] *had the shoulders and I just lifted the front up to get her in the house...* [It was] *bitterly cold. Fortunately, someone had the sense to put a shawl round her shoulders.*

Lack of support

339. Many patients need social service support after discharge. Not all receive it appropriately. One family told me how they felt pressurised to accept the discharge of their elderly dependent mother who had not had an expected social service assessment:

This wasn't until she was on Ward 10 that the person in charge of discharge, whose name I can't remember, it was a nice young man, but he was quite persistent in saying: we are looking to discharge your Mum, she is a lot better. And I was saying: we are still waiting for the social worker's assessment and as she is now, I do not feel I can have her back home. Because she had a granny flat. It was upstairs. None of our toilets were big enough to get her in there, if she needed a wheelchair.

... He was saying: she is ready to be discharged and where was she going to? I was saying to him: we have not got anywhere for her to go to yet. And I had to say that several times, on different days... There was a worry that they would get her dressed and put her stuff in a bag and just plonk her at the end of the corridor kind of thing and I would find her there. That is what worried me. Nobody said that but that is what worried me. That she would not be happy with that...

340. Another ill-prepared family had to cope with the consequences of an inadequately thought-out care plan:

She found it difficult at home. She was sent home with three carer visits each day, and on the first day, we found that [the patient] *was unable to administer her own medication. You know, in taking into account what had gone on in those days that she had been in hospital, she was no longer able to administer it herself and the carer came and didn't know what to do, and it was over to us, and* [her son] *was making phone calls to all and sundry to find out how to administer the insulin and which tablets and that. We were pretty shocked that nobody had thought of this before she went, you know. The onus was on us.*

Yet as far as we knew, she had been discharged with a care package which was suitable for her. It wasn't.

Comments

341. The problems of discharge without adequate support or planning are not confined to this hospital, and satisfactory arrangements are subject in part to cooperation from other agencies. According to the 2008 Care Quality Commission National Inpatient Survey, the percentage of people who said their discharge was delayed has continued to rise, from 38% in 2005 to 40% in 2008. Of those who waited, 21% waited for longer than four hours. Waiting for medicines remained the main reason for delay. This Inquiry has not investigated the adequacies of the support services in the communities served by the Trust but I have the impression that they may not be entirely satisfactory. However, the burden of the complaints of the type presented above is directed at matters which are within a hospital's power to address. All hospitals are under pressure to discharge patients in order to admit others – and I have heard how problems developed in Stafford A&E in part because of difficulties in discharging patients from wards. That pressure should not be allowed to influence managers and clinicians into discharging patients who are not ready or for whom the necessary arrangements have not been made. Patients who need to be fetched, cared for or otherwise supported by relatives or carers should not be discharged without adequate warning and information being given to them. Finally, if patients are required to wait in places other than in a ward bed, they should not be expected to remain in an area ill equipped to cater for their needs. I have been shown the discharge lounge and agree with the present Chief Executive's assessment of it that it is a depressing place. The Trust has told me that it has plans to re-locate the discharge lounge and for it to be staffed by clinical staff. All elements of the discharge process, such as medication and arranging transport, will be addressed within the lounge prior to a patient being discharged or transferred.

PATIENT STORY

I heard from the husband and son of a woman who sadly passed away in April 2009, just 54 years of age. Her husband said that during her illness he had *"never seen such a brave woman in my life"*.

The patient's husband wrote a very moving letter, which he entitled his wife's story. He told me his reason for writing this: *"I wanted to get things down on paper while it was still fairly fresh in my mind, although to the best of my recollection, as it were, telling the story to myself, I had difficulty believing it myself. It was just – it sounds horrific and it really was and it was a very traumatic time for both myself and my wife and my family, of course."*

He told me that, prior to 2008, his wife was in good health. In early 2008, however, she began experiencing minor stomach pains which, as the year went on, became increasingly more severe.

In June 2008, the patient's GP referred her to Stafford Hospital. In September 2008 she underwent a series of tests, including a CT scan, which revealed prominence of the pancreatic duct, which was interpreted as being consistent with pancreatitis. Her husband was unhappy with the consultant's attitude, primarily as he seemed to be convinced that his wife was suffering from alcohol-induced pancreatic disease. Her family constantly emphasised that she only consumed alcohol occasionally and never to excess, and indeed had drunk very little since her first pregnancy in 1978. The family believe that the consultant's assumption and refusal to listen to the family clouded his judgement.

Prior to being discharged from hospital, the patient was visited, in error, by a Macmillan nurse, as no diagnosis of cancer had been made at this stage. This caused great distress to his wife, as she was extremely frightened of being diagnosed with cancer, particularly given that she had lost her mother to the disease. The Trust apologised for the mistake and explained that the mix-up was because there was another patient with the same surname on the ward who had been diagnosed with cancer.

Her husband told me that his wife then underwent a procedure to have a stent inserted into her bile duct. Following the procedure, the consultant informed her that she would receive notice of a follow-up appointment within the next 14 days. After 12 days, her husband contacted the consultant's secretary to enquire about the appointment and left a message on the answering machine. The following day he received a call from the consultant's secretary asking why his wife had failed to attend her appointment; the secretary was adamant that she attempted to return his call the previous day. He made a further complaint to the Chief Executive, who simply responded by setting out the secretary's account of events.

When a follow-up appointment was offered, they met with a different consultant who suggested that the patient visit her GP for a diabetes check-up and she was subsequently diagnosed with type 2 diabetes.

In February 2009, the patient attended a procedure at Stafford Hospital in order to have the stent in her bile duct removed. She was given an 'urgent' follow-up appointment; however, the date offered was four months later.

His wife's pain, however was becoming unbearable and she was losing considerable weight – half her body weight in six months. Her GP made three attempts to contact the consultant to bring forward her appointment but did not succeed. The GP then made a referral to a surgical consultant, through the Choose and Book system, for a second opinion as an urgent patient. However, there were no earlier appointments available. It was at this stage that her husband decided "*enough was enough*", and he made a formal complaint to the Patient Advice and Liaison Services (PALS).

At the beginning of March 2009, his wife's pain intensified and her husband rushed her to A&E. She was admitted to Ward 7, where she was treated for dehydration and her pain was brought under control. The following day she was seen by a surgeon who ordered a review of her previous tests and ordered further blood tests and an ultrasound scan. The surgeon informed the patient and her husband that he strongly suspected cancer of the pancreas with metastasis to the liver. He said a CT scan and a liver biopsy were needed to confirm his suspicions. These tests were undertaken immediately and confirmed the diagnosis, and the prognosis was that her condition was inoperable and incurable.

Following extensive discussions with the Macmillan nurses and given her poor physical health, the patient decided not to undergo chemotherapy. Tragically, she passed away at the beginning of April 2009.

This lady's husband has referred her case to the Independent Case Review and is awaiting a report from it. He was also keen to tell me of his own experience as a patient; he had been an inpatient at Stafford Hospital on four occasions and his overall experience was good. He went on to describe the team who performed his femoral bypass as *"brilliant"*. He remarked, *"Everything in the hospital is not bad."*

He commented that he would like to see improved communication in the hospital and that if the doctor treating his wife was at fault through negligence, then he should be dealt with by the appropriate authority.

He concluded by telling me that the purpose of him coming to the Inquiry was to *"highlight the points... to be put right for the future so nobody else has to go through the trauma that my wife and myself and my family have been through... If they can correct all those problems and put the hospital back on the map as a good hospital, then I have achieved my aim."*

Section B
The culture of the Trust

Introduction

1. The definition of "culture" when examining an organisation such as an NHS Trust can be stated as *"the predominating attitudes and behaviour that characterise the functioning of a group or organisation"*. In addition to hearing about specific instances of poor care and deficiencies in service provision, I also heard a great deal of evidence which described general behaviour and attitudes, accepted ways of doing things, and other indications of the values adopted or accepted by those working for the Trust at all levels. From this evidence, it was possible to build up a picture of the organisation's culture. The impression given by the evidence of both hospital users and staff was not an encouraging one. I shall consider this topic by looking at a number of themes.

2. I have heard evidence from patients and their families, which has raised concerns about the:

   - attitude of patients;
   - attitude of staff to patients;
   - attitude of staff to visitors; and
   - differences between wards.

3. I have also heard evidence from staff about matters which give a picture of significant elements in the organisational culture:

   - bullying
   - target-driven priorities
   - disengagement from management
   - low staff morale
   - isolation
   - lack of candour
   - acceptance of poor behaviours
   - reliance on external assessments
   - denial.

Concerns raised by patients and families

Attitude of patients

4. A common attitude among patients and their families was that they were reluctant to insist on receiving basic care, medication or other forms of attention, for fear of upsetting staff, perhaps leading to a reduction in the care they received, or even out of concern that they might get a member of staff into trouble.

5. A typical comment was made by the mother of an elderly woman who found the ward to be severely under-staffed:

...there was very few care assistants on the ward that were caring, but the ones that were, you felt you had to look after, and Mum kept saying to my niece: don't make a fuss, you will get her into trouble, don't make a fuss. That's all she kept saying, even the following day when I came on. She said: leave it, leave it, you will get her into trouble.

6. The same witness refrained later from raising her concern that medication had not been given because of a nurse's demeanour:

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

7. Another witness actually expressed similar fears to a nurse about raising a concern with Patient Advice and Liaison Services (PALS), and this was recorded in the patient's notes. She explained to me:

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

8. Another witness found that there were members of staff she was not prepared to raise concerns with:

   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.

9. She therefore raised concerns with two bank staff whom she found to be more approachable.

10. The wife of one patient felt that her husband had not persisted in seeking pain relief because:

    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.

Attitude of staff to patients

11. Patients and their families described to me a range of attitudes presented by staff, from being caring and compassionate in spite of a very difficult working environment, to one of not appearing to accord a high priority to their patients.

12. I heard of inappropriate explanations or reactions being offered for deficiencies in care. As noted above, a nurse told one visitor not to *"moan"* as she had had *"no break today"*. The same witness described an occasion when there was an issue about whether her confused mother had refused medication. She was met with a confrontational reaction:

    I said: I think there must have been a communication problem because the nurse – her English wasn't very good. I said: I think Mum must have misunderstood what you were saying. And the ward manager said: so you want your drugs now, do you? And I said: yes, please, if you wouldn't mind. And they just threw back the curtain and just marched out the room.

13. She received no more encouraging a reaction when she raised the issue about patients not getting water to drink:

    I would say to the nursing staff, some of the nursing staff: would you leave water out at night. Night after night after night I asked for them to leave water for the patients. We can't. I said why? Because the jugs have to be washed... And they were just as cold as that, even after I had said to them: but they want a drink during the night. But we have to take the jugs away, they have to be sterilised. It is either that or infection. But they were just dismissive of the patients.

14. Another patient admitted to the Accident and Emergency (A&E) department was reprimanded by members of staff for calling his wife:

    ... when I was told I was to be admitted, I was left in a small cubicle for several hours on a trolley, no pillows, no blankets, and when I rang to tell my wife, I was admonished quite sharply by someone who told me to 'get a life' and not use the phone in hospital. Eventually I got a pillow and then an hour later, a blanket arrived which I refused because it was covered in someone else's blood.

15. Some nurses displayed a lack of compassion when it was clearly needed. The relative of one patient reported a loss of temper when the bed was soiled by accident:

    ... he said: I need to go to the toilet. ... he said she seemed quite angry that he wanted to go to the toilet. So she flounced out and went to get a bottle and she came back in and – yes, the urinal wasn't on the bed – well, it was, because, yes, she had gone out and she went to get the bottle, and she came back in and he had done it because she took quite a while to get the bottle and she was due to go on a break, and he said to her: I'm really sorry but I have done it, and with that she exploded. She threw the urinal down on to the bed and she pushed his trolley up against where he was with his dinner and she went out and she never came back.

16. The sister in charge of the ward said she would reprimand this member of staff and later reported that she had apologised, but this was not reflected in the records seen by the relative. What the records that I have seen do confirm, however, is that the member of staff accepted she had forgotten to come back with a bottle.

17. One member of staff on Ward 11 was described by a number of patients and their relatives as being very unpleasant to patients. He was reported by one patient, a retired nurse herself, as humiliating her by insisting on taking her to the toilet even though she asked to be accompanied by a female member of staff.

    I must say here that I have worked with male nurses, and they are just like any other nurse, I would trust them, but it was just something about his attitude. It was not conciliatory in any way. He was just standing there saying: I will take you. And I protested quite a bit really and I got quite tearful, because he was – he was saying: I'm trained, I can take you. It didn't occur to me at the time – it has since – that if the female nurses or carers are busy, why didn't he just go and relieve one of them. That's what we would have done in my day... we ended up arguing and this seemed the most incongruous thing to happen between a professional person and a distressed patient – over toileting, for goodness sake. And then he said: there isn't – he kept repeating this and I said: I don't believe you. And his words said: are you calling me a liar. And I said no, and this is in my tearful state. I said: no, I just don't believe you. But it went on for so long, and by this time you can imagine I had waited a long time. I didn't want to be embarrassed by making a mess. I said – I allowed him to take me.

18. The same witness summed up her experience of the nursing staff in this way:

    I think the lack of compassion was so notable. Kind words, professional words really from people in whose hands you were. If a trained nurse had come and talked to me or made herself known to me when she came on duty, that would have made me feel that I was valued in some way.

19. In one striking case, I was told of the unsympathetic attitude displayed by staff after an elderly patient tried to take his own life. His relative was present and described how a nurse *"lambasted"* him and told him it had been a *"selfish act"*:

    As for the care that he received following the attempted suicide, he was visited by somebody from the psychiatric liaison team who spent quite some time with him. My father was lambasted by one of the senior nurses for the suicide attempt because she said it was a selfish act.

20. While a firm response could be called for, it should be possible to combine such an approach with sympathy and understanding.

21. In another striking case, the patient was apparently mocked over his religion:

I was particularly upset one morning, this particular nurse was on the morning staff, a male nurse, and he upset me so much because he – I don't know what he said, but he had a laugh about the palm cross at the front of my Bible... I don't know what he said, but it was most upsetting and I didn't say anything because of reprisals... he said something about starting a fire...

22. Not surprisingly, both the patient and his wife were distressed, and they both considered that this member of staff *"was a bully"*:

I got the impression he was a bully because he was taking advantage of us in a vulnerable position.

23. Some nurses demonstrated an uncaring attitude by openly discussing their own personal issues in front of or with patients, or by ignoring them. One witness told me:

I think my experience with the nursing staff, they don't actually – it isn't care at all, it is – you are a number... there were two paramedics, one male and one female, and they spent 20 minutes discussing this diet that she was actually going on and how much she had lost. I could hear all of this going on and yet there are people around. This is in work time. Don't get me wrong, everybody should have a time to actually have free time but there is a time and a place and it is not when it is on the ward, when it should actually be the care of the patients.

24. Another witness observed nursing staff appear to be more concerned with their own health than the interests of the patient. A patient had fallen out of bed, and there was a delay between help being summoned and the arrival of two nurses. The witness described one of them saying to the elderly patient, who was still on the floor:

"What are you doing down there? Well, you will have to help to get yourself up. My mate is eight months pregnant and she mustn't lift." Those were the very words. I will never forget. She should have been full of concern: are you all right; do you hurt anywhere? It just was as if it had interrupted the rest of their programme of whatever they were doing, instead of it being a very serious matter. That woman could have re-broken her hip. I just was shocked.

25. The son of another patient told me of the inappropriate expression of her own feelings that one sister used when talking about finding his mother on the floor after a serious fall:

I says: now you have come in this morning and you find my mother has had what is potentially going to be a fatal fall. I said: what are your feelings on that? She said – this is in front of the whole family, she said: do you want to know what I said off the record? I said: I want to know what you thought and what you said. And she said: I said, oh bloody shit. And that was a professional person talking to people that were going to lose a loved one. That was her answer to me.

26. When asked about this, the sister told me she could not recollect using this expression and agreed it would have been unprofessional to do so. She *"doubted"* she would have used such an expression. I regret to say that I formed the impression from the way she gave her evidence that she might have used it. Whether or not she did, I have no doubt that the daughter gave me her honest recollection, which must have resulted from an unfortunate impression being given by the nurse.

27. Another witness complained about how the nurses used to talk to each other:

I sat, held his hand and wiped his face and his hands and washed his mouth... Just there to comfort him and do whatever I could. But they didn't hide the fact that they didn't like me being there... They just totally ignored me. There was no niceties. There was no: good morning, Mrs ..., how are you? When they did anything for [my husband]*, it was never:* [his name] *I am going to do so and so; or Mr* [...] *or whatever. They just treated him as if he wasn't there. Do you know what I mean? As if he was just – well, as I said, a log of wood or something like that.*

28. In another case, a patient was distressed by nurses talking within the hearing range of her and her husband in a way that they regarded as derogatory of patients:

There were two nurses that were actually talking about the patients, and they were laughing about them, and my husband did actually turn round to them and say: excuse me, I might have had a stroke but I do know what is going on... They had just come out of the ward and were laughing and saying about the smell in there, and they were talking in general, thinking that because he had had a stroke, he wasn't able to understand that they were actually taking the mickey out of the patients.

29. In another incident, a nurse reacted badly to being told of a patient's problems by a family friend:

    [Our family friend] *was so appalled at the state of Mum and she spoke to a male nurse and said: I think this lady is uraemic. And he flounced along the ward and he grabbed hold of the curtain and he pulled it round, it went right out into the aisle. And* [Our family friend] *didn't say anything to him. She went back to see Mum, and she came straight back out and she dressed him down in front of everybody. He tucked Mum in so tight that she was absolutely rigid and she couldn't move.*

30. One patient found that he was ignored after he complained about the lack of water:

    There simply wasn't sufficient water jugs to go round. So he was left totally without any drink. He had actually complained, hadn't he, about the treatment he had received from one nurse whilst there? And as a result this nurse totally ignored him for the rest of his stay; like she would walk by the bottom of his bed, he would ask for help or a drink and she just totally ignored him.

Attitude of staff to visitors

31. Many families who were visiting relatives did not feel welcome, even though they were providing care that the patient needed, and that the staff, often through understaffing, were unable to provide themselves.

32. The family of one patient told me:

    It was really like they could have done with just the patients there and sod the visitors. They were just a nuisance, just a thing in the way. That was our impression.

33. Another witness was unacceptably rebuffed when she asked where some pillows she had brought in had been taken to:

    I actually wrote his name on the pillows with big letters, so he would keep the pillows, but they disappeared when they transferred him to Ward 10. I asked the nurse from Ward 10 if she would get my Dad's pillows back. She was rude, really. She turned round and she just said to me: huh, I suppose I have to go on a pillow hunt, have I? I said: yes, you have. We want the pillows back.

Differences between wards

34. Some witnesses commented on the vast difference in atmosphere between wards. The family of one patient who was moved from Ward 6 to Ward 7 noted:

> *It was like going to another country... we both learnt how to change the bottom sheet and the top sheet in a bed without moving the patient out the bed; give my Mum a bed bath and the nurse was saying, are you sure? I said: yes, of course, I am sure. She said: I would not like to bath my Mum, give my Mum a bed bath. I said: I am fine. We done everything for my Mum with their consent and because they were busy, they approved... I never done anything out of the way, tried to be as unobtrusive as possible and they were grateful for it and they were very pleasant.*

35. Another witness pointed to the *"excellent people"* in the coronary care unit, contrasting them with staff elsewhere whom she regarded as bringing *"shame"* to the nurse's uniform.

36. One family were able to distinguish between Wards 1, 7 and 11:

> Q: *Are you able to give any indication as to why the nurses were different on* [Wards 1, 7, 11]*? What was it about them that was different?*
>
> A1: *I think their attitude, and I would say that on Ward 1 generally, I can't say that there was anything negative about the way in which they dealt with patients or tried to make it easier for relatives...*
>
> A2: *It seemed more like on Ward 7, in and out, in and out.*
>
> A1: *And nobody with an overall view of care.*
>
> A2: *I think the sister who was on Ward 11, she was doing the job of herself plus however many nurses, so she was visible all the time.*
>
> A1: [On Ward 11] *She was very approachable as well. She got on well with the other staff as well. She seemed to have a good team there. She was lovely.*

Concerns raised by staff

Bullying

37. I heard much evidence suggesting that members of staff lived in an atmosphere of fear of adverse repercussions in relation to a variety of events. Part of this fear was promoted by the managerial styles of some senior managers. Former Director of Human Resources, Norma Sadler agreed that an explanation for staff's reluctance to come forward with concerns was that they were scared:

Yes, people were scared. They were scared in the organisation, they were scared of repercussions and very often I would have people coming to my office, because I operated an open door policy. They would ring up and say: could I talk to you. They would come down to my office and sit there and I would listen to what they had to say. Sometimes it was around bullying and harassment that they would come and talk to you about. I would say: fine, I have heard what you said. I am happy to take this forward for you. Because the process was if they came and laid and their concerns before me, I had listened to what they had said, … some of them who came in wouldn't take it forward. They would come in, offload to me but wouldn't want to take it any further.

38. A manager of the Trust between 2007 and 2009 wrote to me about her experience of bullying at the Trust. Although she was a senior member of staff, she felt she had no autonomy and was excluded from meetings that she felt were essential to attend for the success of the project. She took two weeks' sick leave due to the death of a relative and was replaced while she was on leave by another manager. She felt that the impression given by others was that she had failed. She said she blamed herself for not being able to cope and lost confidence in her abilities.

    She described an *"endemic culture"* of bullying at the Trust (with the exception of Dr Suarez, who was supportive of her). She felt that all the executive team were in *"a downward spiral of bullying and the inexperience (CEO, COO and Dir of Nursing) was creating a situation of a compete lack of leadership"*.

39. The former Director of Clinical Standards, Mrs Jan Harry, was frequently mentioned by witnesses as having a management style which was forceful, and was viewed by some as bullying. Ms Sadler told me: *"People were very afraid of the director of nursing* [Mrs Harry]*"*. She agreed that they had good reason for this:

    [Mrs Harry] *was very unapproachable, very aloof. She didn't like to be criticised at all. If something was happening that she didn't approve of, didn't like, then your life was made hell. Several of the nursing staff who came to talk to me about their problems they had got with her were saying: I can't do any more because if I do she will just make my life hell.*

40. Mrs Harrys' deputy in 2005/06 found her *"visionary"*, but also *"antagonistic"*:

    She was very forthright. She had her view and her view was often the only view that could be seen as being correct. She didn't take challenge well, although we did discuss that, and she said that was part of – one of the roles that I had was to challenge her, but I know that other people that did try and challenge her were quite often sort of berated down and dismissed very quickly.

41. The former Chair of the Trust, Ms Brisby, told me that she had been instrumental in arranging for Mrs Harry's departure from her post because of her management style:

There were certainly people who were very very unhappy with her management style. There is a fine line between management and bullying but there were people who complained about [Mrs Harry] *being a bully.*

42. The former Director of Pharmacy, Mr Hynam, told me of his belief that staff had become demoralised, and even bullied, during Mrs Harry's time as Director of Nursing [as he described her post]. He was aware that some staff alleged Mrs Harry was a bully and that on one occasion she had been obliged to apologise for bullying.

43. The Trust's Solicitor and Company Secretary, who worked with Mrs Harry only for a short time, responded to the following question:

Q: *...we have heard it suggested by some people that she had a, to put it politely, robust management style; that she could be abrasive... It has also been suggested that she could be a bully.*

A: *Yes, I have heard that. I only worked with her for a very short period of time. That would be my experience and that is certainly the reputation she had when I arrived in the Trust... I didn't see how she treated others because we were in different buildings, but she was abrasive with me. She didn't try to bully me but I certainly heard from others that she did.*

44. A Band 7 senior sister told me:

[In] *my personal professional view, that she did not provide good clinical leadership for the nurses in the organisation. She had a closed door approach and her introductory statement to us at our first meeting was that we hadn't got to go to her with any problems; that she wasn't there to solve our problems; we could solve our own problems. If we went to her with a solution, then she felt her job, her remit was to find the resources to help us to solve our own problems. So I do not feel that she was particularly approachable, never saw her* [do] *clinical* [duties], *and there were nurses in the organisation who didn't know what she looked like, didn't know who she was. She was actually challenged on one occasion by a nurse, who got quite severely reprimanded for not knowing who* [Mrs Harry] *was, but she had never met her, never spoken to her, never seen her in any way, and so wasn't aware that that was the chief nurse.*

45. Another senior nurse, with 20 years' experience, said:

She wasn't somebody that you could talk to about anything without being shouted at in my experience. So we would never have felt that we could have gone to [Mrs Harry] *with anything that was troubling us... she was very aggressive in her manner and she did shout and shriek at you....*

46. Yet another nurse, who worked as a matron for three years, told me:

[Mrs Harry] *didn't engage with the nursing workforce; didn't ever request to speak to anybody; basically came to bed meetings and bullied everybody to get discharges.*

47. Mrs Harry was asked for her response to these allegations about her managerial style, and she denied them. As to whether she was aloof or intimidating she felt this was a matter of opinion. Mrs Harry accepted that she did not spend much time on the wards and could understand why staff might feel she was unapproachable, although she did not think this was actually the case. She told me she had worked very hard to get away from a culture of blame. She agreed that she may have told people to bring her solutions, not problems, as she wished to foster initiative in an organisation where she found that people waited to be told what to do:

I wanted people to be able to think for themselves and also feel that they were empowered and had the ability to make decisions for themselves.

48. My conclusion is that, whatever Mrs Harry's intention was, she was perceived to have an abrasive and bullying style of management by a significant number of staff members and management colleagues. I have no doubt that this led to the reluctance of some to approach her with concerns or suggestions.

49. A management style giving the appearance of bullying was not confined to director level. I heard evidence of a culture of bullying within the A&E department. In particular, I heard about two sisters in that department bullying other members of staff in relation to the waiting-time targets, and harassing one colleague when she raised concerns with management. Much of this is addressed in more detail within the report.

Target-driven priorities

50. As will be seen, the Trust Board placed a high priority on compliance with nationally set targets, and, in particular, the four-hour waiting time target for A&E. The pressure to comply with such targets came from the Department of Health (DH), the strategic health authorities (SHAs) and the primary care trusts (PCTs), as explained by the then Chief Operating Officer:

Q: *But the consequence of failing to meet a target was essentially that it would reflect poorly on the Trust when compared with others?*

A: *Yes but it would be more than that because it would be performance managed via both the PCT and the SHA at the time against what was happening, why the required standard wasn't being met and what actions the organisation would take to improve and reach the required –*

Q: *So your successor in the post at the SHA would be on the phone to you saying: why isn't this target being met?*

A: *Yes, and what are you doing about it, and similarly from within the PCT.*

Q: *Was there pressure being brought to bear on you not only from within the Trust but also from the PCT and the SHA to ensure that these targets were met, or to explain why, if they were not met, that was?*

A: *Yes, and beyond that because ... there was a team within the Department of Health which likewise was looking at any outlier performance and would expect through the SHA an understanding of what was happening and why it wasn't being – why improvements weren't being seen.*

51. And with specific reference to the A&E target:

I think we were all put under pressure to meet the four-hour target. It wasn't just something that was unique to Mid-Staffs. And there was very much a sense from the SHA, the PCT, Monitor, the Department of Health, that that was a required standard that patients should be able to be clinically dealt with within the department within the four-hour threshold. I do not believe anyone used bullying tactics.

52. Financial matters will be considered later in this report, but this witness described the nature of the externally originated pressure to meet targets in general and financial targets in particular:

There was a lot of national pressure around making sure that targets were reached and that, along with that, finance was one of those targets, and it was deemed that it was not acceptable and going back to the 2005/2006 nationally, it was a very clear directive from the Department of Health/SHA that all organisations had to achieve a financial balance going forward on a recurring basis.

53. There is no doubt that the pressure generated fear, whether justified or not, that failure to meet targets could lead to the sack. The Chief Operating Officer, Karen Morrey confirmed this:

Q: *And that it was a sacking offence not to get that right?*

A: *Yes. As were lots of other things, as were not achieving the targets, that was a sacking offence.*

Q: *Is that an environment that makes for a happy ship, do you think?*

A: *I think it makes it for a very highly pressurised, a highly pressured ship. It is absolutely relentless, around the pressures that people are under in that environment.*

54. She later explained that the sacking offence referred to Board members, however I find her original use of language instructive.

55. A former non-executive director stated:

As a board we were very keen to ensure that we didn't breach the A&E – or tried not to breach the four-hour waiting target. But again, this was very common in the NHS. Again, there is a lot of pressure from the strategic health authority and in any meeting with any health authority, what they would focus on would be the targets.

56. Another former non-executive director commented:

Can I say that breach of the four-hour wait in A&E was a particular hobby horse of mine. Coming from industry, I expect targets to be met, and I was regularly – we breached – don't get the impression we never breached the four hours, we did and every time we did, we questioned [the Director of Nursing]*... So we were questioning. Every time we breached we questioned....*

57. Although the Chief Operating Officer expressed the view to me that patients needed to be treated in the right manner, even if this was at the expense of the target, this was not the way the Board's interest in targets was interpreted at the front line, and it was not the perception some held of how she managed this.

58. A nurse who endeavoured to blow the whistle by reporting her concerns told me:

[The Chief Operating Officer] *was one of the worst for frightening people, coming down and pressurising people, which is why it led to lying....*

59. Ms Morrey has denied this allegation as she does not regard this as representative evidence.

60. A newly arrived directorate manager in emergency medicine described to me how she realised what A&E staff expected to happen as a result of a target breach:

I came from a meeting one day and one of the staff nurses were crying in the department and I said: what on earth is the matter? And she said: I have had a breach. I went: right, and? And she was literally quaking in her boots because she thought I was going to shout from the rooftops. And I said, it is not a problem. We haven't got to be like this at all... on occasion you would expect patients to breach for clinical need...

61. An emergency physician told me:

The nurses would go into that meeting and they were told in the meeting that [if] *there were any breaches to – that is breaches of the four-hour rule – they would be in danger of losing their jobs. On a regular basis, and I mean a number of times per week, when I was on day shifts, I would see nurses coming out of that meeting crying.*

62. The A&E consultant agreed that senior nurses would pressurise junior doctors to discharge patients to meet the target:

[They would] *say: look, come on, someone is going to breach in 10 minutes, and sometimes they would be asking the senior to go and sort out the mess or make a decision.*

63. This evidence satisfies me that there was an atmosphere in which front-line staff and managers were led to believe that if the targets were not met they would be in danger of losing their jobs. There was an atmosphere which led to decisions being made under pressure about patients, decisions that had nothing to do with patient welfare. As will be seen, the pressure to meet the waiting target was sometimes detrimental to good care in A&E. This is inconsistent with the guidance about targets published by DH:

It is vital that this target must not in any way jeopardise the quality of clinical care offered to patients....

64. The same guidance distinguishes between clinical exceptions to the target, where A&E provides the only appropriate facility and expertise for the patient's condition, and breaches where *"equally appropriate facilities"* are out of action or full.[22]

65. The difficulty for front-line staff and the Board alike is ensuring the best interests of the patients, and staff must not be deterred from looking after patients' best interests by over-rigid application of the concept of a breach. Where there is room for doubt or debate, the decision must always err on the side of patient safety and welfare.

[22] Department of Health (2003) *Clinical exceptions to the 4 hour emergency care target*, London: DH

66. Fear has also manifested itself in the reluctance of staff, particularly nursing staff, to come forward to the Inquiry. The number of nurses who contacted me and offered to give evidence, either written or oral, was disappointing, particularly in the light of the considerable efforts made to persuade them that it was safe to do so. Meetings set up at the hospital for nursing and other staff to meet the Inquiry were, in general, not very well attended. I was able to see some members of staff in private and informally, and obtained much useful information that way. However, a constant refrain from staff who summoned up the courage to report matters to me that might cast a negative light on the Trust, was *"I cannot believe I am saying this"*, implying that disclosing matters of concern about standards or safety was in some way disloyal.

Disengagement from management

67. I heard convincing evidence that the clinical consultant body largely dissociated itself from management. A former chairman of the consultant staff committee told me that it was difficult to attract attendance at meetings, unless car parking or secretaries were on the agenda:

To the extent that sometimes I would put car parking on the agenda, because I thought that might actually get one or two more people around.

68. He agreed that there was a lack of engagement with management proposals for change, such as the clinical/surgical floors project [see below]:

One has to accept that there is no way that doctors can be experts on nursing practice. And nursing practice changes just as much as medical or surgical practice does. So I think that there would have been a resignation to going along with what has been planned and saying: well, we will see how it works out and if it is better, then great, and if it is worse then we will readjust it later.

69. This was certainly reflected in the attitude of some of the consultants who gave evidence. One surgeon told me:

I feel there were a lot of management changes being driven through and there was precious little we could do to influence that matter, even though we voiced our concerns.

70. This clearly led to a fatalistic approach and an acceptance that they could do nothing:

You acknowledge that you are understaffed and overworked and you need more colleagues to give you a bit of a hand but that is never forthcoming. You say that you need so many extra colleagues but – you make the argument but in the end it always gives way to financial pressures.

71. Even if, as he thought, the situation had become unacceptable, he felt that they were:

obliged to carry on with what we have got.

72. Another consultant, a physician, commenting on the surgeons' attitude towards the changes in the ward arrangements, told me:

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

73. The 'Stafford way' was perhaps clearly reflected in the evidence of a surgeon, who, asked about the financial issues which beset the Trust, said:

I am somebody who does not have much engagement with the senior management. I do my job. I put my head down. Do the job and get on with it. Personally I was not totally aware of the difficulties, that is all I am saying.

74. I also heard of the difficulties in recruiting a medical director from among the consultant staff when the post was part-time. Dr Suarez only applied for the post after turning it down on one occasion, only to find that no one else stepped forward. She had turned the offer down firstly because she had been out of management for some time and also because she did not think she would be a *"good team fit"*. She agreed that there were relatively few consultants prepared to take on management responsibilities:

We are a relatively small consultant cohort. If you have a big hospital, there are a lot more people to choose from, and I think it is also true to say that a number of the more junior consultants would perhaps be more interested in taking up managerial responsibility, but they would have to cut their teeth on somewhat lesser roles first. I am encouraged for the future, but at the time at which I became medical director, you are right, there were only a few people who were engaged in management positions.

75. A more widespread and even more troubling reaction to management among staff has been not to trust them, an attitude that persists to this day. One nurse interpreted a letter sent by the current Chief Executive and chair of the staff side, which encouraged cooperation with the Inquiry and explained that there would be no disciplinary consequences for doing so, as meaning precisely the opposite:

I did think to myself a little bit that if you have to write to somebody and say: we reassure you that no disciplinary action or whatever will be taken against you, that kind of makes the thing go into somebody's head. And I certainly thought that makes you think: if you go to that Inquiry you are in trouble ..... I have spoken to a number of people about it and said: you saw in the letter everything will be alright. And they said: yes, but we know that is not necessarily true.

76. The current Director of Human Resources, Ms Christine Lloyd-Jennings, put this down to a breakdown of relationships between the staff side and management:

... it is this building up of trust, isn't it, of your staff who don't trust the management. The trade unions when I came hadn't sat down with management properly to do any negotiation on policies, jobs; there had been no agenda for change evaluation panels run here for nearly a year. There was a complete breakdown of relationships. There was no trust. They didn't believe the managers would – they thought they were being underhand, not being open; whether they were or not, I can't judge, but that is the impression I got. That you just didn't put your head above the parapet because you would be in trouble if you did, and there is still now this culture that – do this because if you don't do it we are all going down. There is still that belief out there. There is a blame culture out there still. Antony [Sumara] *is a good figurehead up there and people will see him but he has only been in there a short time.*

People see me and I have a different approach to things as well. They say it is alright you saying that but you are not going to be here for long. What happens when you go? Who is going to protect us then? There is real fear in the organisation.

77. The former chair of the consultant staff committee, speaking of the last days of Mr O'Neill's time as Chief Executive, talked of the gap that existed then between management and staff:

I mean... the executive team at that time was very much inward looking. I mean, it was a small cabal who ran things but didn't get out and about much and meet the people. That was in the latter days of David O'Neill's time as Chief Executive, where he wasn't great for getting out and chatting to the staff either. There was a feeling that management held everybody at arm's length.

78. The current Medical Director, Dr Manjit Obhrai, contrasted how he was trying to engage clinical staff with what appeared to have occurred before:

What happened is that the previous management structure with the three heads of division was such that some of the consultants felt that they did not have a voice at the top table. Part of the reason for changing that was now with the

clinical directors, like this afternoon, there are four clinical directors meeting in Medicine to look at the new way forward for emergency care. That was unique. That is wonderful because that is what you want, the clinician on the top table. So there was a feeling of disconnect. I think now people are coming up with ideas, come to Antony [Sumara]*'s office Stephen* [Moss]*'s office because the doors are open. Nobody is saying you can't go through such and such a structure. Everybody comes in with ideas.*

Low staff morale

79. Not surprisingly, there was evidence that since the publication of the Healthcare Commission (HCC) report staff morale has been low. They have had to face the almost constant negative publicity, the scrutiny of further reviews, and investigations. Mr Sumara, the current Chief Executive, told me what he found when he arrived:

    ... a sense of the staff being very bruised and battered by the experience of the Healthcare Commission report and the unprecedented scrutiny that they had been subjected to as part of that, and suffering low morale and actually being quite angry about the way that they had been treated.

80. A senior advanced practitioner in A&E who has been at the hospital for many years told me:

    They felt demoralised and degraded by the whole thing really, they didn't want to come to work and it is only really in this last week where we have had some good news with the recent Dr Foster report, where it showed us to be in the top 10 of the country for patient safety, which has made me think, yes, we are not necessarily as we have been reported. The hospital of death, headlines in the paper. It was just dreadful to be associated with the Trust, really. Although I am proud to work there I felt ashamed to work there in the same and I can't really quantify that but it was a mixture of those emotions and almost fearful of saying where you worked. If people asked you where you worked you were ashamed to say where you worked. I obviously intend to continue work there but it has been very, very difficult for the staff and that is still ongoing to this day.

81. However, I consider that staff morale had been low for some time before the concerns about the Trust came to the public's attention. The constant strain caused by financial crisis, staff cuts and the consequent difficulties in delivering an acceptable level of care have taken their toll. Many staff will have been concerned about their job security, while others will have felt the stress of the target-driven culture already described.

82. One nurse described the impact of cuts on staff:

As I say, quite a few of the experienced nurses started to leave and I think that was just a reflection on the morale at the time.

83. A porter eloquently summed up the atmosphere among staff:

The hospital is insular. Communications are poor – porters are often the first people to tell patients on the ward they... are going for a test. Too many nurses go off on tea breaks together and consultants have lost respect and do not dress as professionally as they should. Some people, including in the portering department, are just waiting to see their time out.

84. There is a sense that many employees will have kept a low profile and tried to get on doing their job. Low morale is reflected in what were observed to be relatively high sickness rates; Dr Helen Moss agreed that they had been "*very high*" at times, particularly across the medical floor. The current Director of Human Resources told me that, while she thought that in general sickness rates had been similar to other hospitals, there were areas in which the rates had been high, up to 14–18%. She observed such rates in wards about which there was evidence that they were badly run. These would also have been the wards with the biggest vacancy rates.

Isolation

85. There is a sense in which the Trust and its staff have carried on their work in isolation from the wider NHS community. It appears not to have been as open to outside influences and changes in practice adopted elsewhere as would be expected. They have often lacked strong associations with neighbouring organisations. There seems to have been a relatively low turnover in staff, both clinical and nursing; it was striking how many of those who gave evidence had been at Stafford for a very long time.

86. The current Chief Executive told me in blunt terms what he perceived about the organisation when he arrived:

Probably not always present, but often present this sense of a very closed organisation, not listening and not welcoming external scrutiny, closed boards, no contact with any other hospital in the vicinity in terms of clinical networks and certainly not at all welcoming to any external organisation that wanted to come in and visit.

87. This was echoed by the Chairman:

One of the things that struck me when I first went there was that the place was almost in a time warp. It was almost like the modern ways of delivering patient care had bypassed them at Stafford. So they continued to do very much the traditional approaches and there wasn't really a focus on a different way of doing things might actually be better for patients. I am sure that reinforces the point [Antony] was making about this very introspective focus in the hospital and this lack of establishing networks outside of the place. Stafford hospital does seem to have a big number of staff that train and stay there. There aren't huge numbers of people being imported from outside, which obviously brings in new ways of working.

88. The former interim Chairman, Mr Stone, was among those who suggested to me that Stafford as a whole was somewhat isolated, having been transformed from a market town and centre of a county to a place bypassed by a motorway. He thought this feeling was reflected in outdated practices and attitudes at the hospital.

89. Ms Lloyd-Jennings, Director of Human Resources, confirmed the impression of low staff turnover and described it as *"very, very low"*. Dr Moss thought that the nursing staff were *"quite a stagnant workforce"* and that this had a negative impact on the organisation:

I think people didn't move around and they didn't gain experience from other organisations, and practice didn't probably progress as quickly as it might have done, because there wasn't experience from elsewhere that was brought into the organisation.

90. This sense of isolation manifested itself in a degree of suspicion of outside organisations. The former Chairman of the consultant staff committee, who has been a consultant at the Trust for over 20 years, agreed with this:

I think there is a geographical problem here in that the Trust has always been looking over its shoulder to some extent at neighbouring hospitals and thinking: are we about to be gobbled up? Certainly in all the time that I have been here, there has been a certain paranoia about, you know, what is happening up in Stoke, and are they trying to take us over or something? I mean, that is not the way it should be. I mean, the value of having a large teaching hospital on your doorstep is that you should be exchanging ideas all the time. I think it is all too easy to become isolated in one's patch and to think that everything is going swimmingly, because you don't actually have a benchmark against which you can compare yourself, and so one of the things that I think needs to change, and indeed is changing to some extent, is that we should encourage a cross-fertilisation of ideas from centres of excellence, and the fact that we are now

working with Keele and taking more medical students on a steadily increasing basis is a very great help, because that, in itself, helps to drive up standard.

91. I found it significant that this witness, a rheumatologist, was largely based at Cannock, rather than Stafford, had funding for staff and his work from more than one PCT, and visited outreach clinics in a variety of places. This may have allowed him a perspective denied to some others.

Lack of openness

92. The Trust was not, until the arrival of the current executive team, run in a particularly open way. Before obtaining foundation trust (FT) status, the Board would sit in private first and then in public. Much business was discussed in private, not always with a very clear justification. Board meetings were not held in public at all once the Trust became a foundation trust because, as it was explained to me,

    as a foundation trust we were going to be more commercial and we would be discussing commercially sensitive issues and that the council of governors would be our public meeting.

93. In addition, *"there was a decision to have regular press briefings following each Board meeting... and then that the public would have access to issues discussed through the council of governors."* Another example was the defensive way in which many complaints were dealt with (see section on complaints). Yet another was the failure to engage staff in the outcomes of incident reports.

94. One specific incident brought to light in this Inquiry has caused considerable concern and is an example of an instinctive defensiveness where openness and frankness were clearly required. This involves the case of a young patient brought to A&E in 2006 and discharged with an injured spleen which had not been diagnosed. The full facts of this case have been set out elsewhere in this report. The patient died of fatal bleeding shortly afterwards and an inquest was called. The coroner invited the Trust to submit evidence. A consultant in A&E, who had not been previously involved in the case, was invited by the former Trust solicitor to prepare a report on the case. The consultant produced a report, addressed to the coroner, and delivered to the Trust legal department. At the time the cause of death was not known but the consultant correctly concluded that a possible cause of death was a ruptured spleen. He also concluded that the death could have been avoidable if a proper assessment had been carried out in A&E. The report was not in fact sent to the coroner. The current Trust solicitor and company secretary then took up her post and picked up the handling of this case. She wrote to the consultant inviting him to change his report. The reasons given in her letter were little short of astonishing:

... as reports are generally read out in full at the Inquest and the press and family will be present, with a view to avoiding further distress to the family and adverse publicity I would wish to avoid stressing possible failures on the part of the Trust... The next paragraph [of the consultant's letter] *expresses your grave concern that the death could have been avoided. In my opinion it is self evident from your report that this is probably the case but I feel such a concluding statement may add to the family's distress and is not one which I would wish to see quoted in the press.*

95. The Trust solicitor and company secretary denied that she had been trying to prevent the consultant's evidence reaching the coroner, which would have been damaging to the Trust. She told me she thought that there *"was something strange about the way he was putting his reports together and there was no intention to hide anything."* While the Inquiry has not seen any other reports from this consultant, in my view there was nothing 'strange' about this report, which appeared to provide a balanced and candid view of the case.

96. Laudably the consultant refused to change his report and assumed it would be sent to the coroner. In fact it was never sent.[23]

97. The young man's family first saw this correspondence at this Inquiry. They pointed out to me that nothing could have distressed them further and what they had wanted to know was the truth about how their son came to die.

98. It was decided to refrain from publishing a summary of that part of their evidence at the time to enable the Inquiry to investigate the matter fully first, and not to prejudice the examination of later witnesses. As a result of that consideration the Trust solicitor and company secretary was invited to assist the Inquiry. She accepted that the report should clearly have been disclosed to the coroner, but was unable to explain how or why it had not been. Following discussion with the Coroner I am assured that he now has all the material he requires with regards to this matter.

99. What is particularly troubling about this unhappy story is that it was clearly thought instinctively by a senior employee of the Trust that an adverse report about care leading to a death should be suppressed, in part because of a fear of adverse publicity, and in part on a ground relating to family distress that can only be regarded as specious.

[23] This paragraph reflects the evidence given to the Inquiry before the report was delivered to the Secretary of State. Since then a version of the report in the Trust's possession apparently amended by the consultant in accordance with the request has been drawn to the inquiry's attention. The Chairman remains satisfied that the adverse opinion of the consultant was not disclosed to the Coroner

Acceptance of poor standards of conduct

100. There has been evidence of an unfortunate willingness on the part of the Trust to tolerate incidences of poor performance and conduct of a type which required addressing via a robust governance structure. The experiences of patients and their families, as related earlier in this report and in Volume 2, include instances – some very striking – of unacceptable behaviour and acceptance of poor standards that ought to have been evident to colleagues and management at the time. As will be seen, such a structure was largely missing or not implemented, but even so it is of concern that more was not done by management and colleagues to address these issues. This was certainly the view of the current Director of Human Resources:

When you read the Healthcare Commission report and you listen to some of the stories you have probably heard over the last few weeks here and from Cure the NHS and the press and everything else, I think there has been instances of very bad behaviour. What amazes me is there is no evidence of that ever being tackled in the organisation. And actually it is difficult because I think you need to tackle poor behaviour, and I think staff respect you if you do and I think trade unions are generally on your side when you tackle those difficult issues.

101. The Trust solicitor and company secretary, throughout much of the period under review, detected an unwillingness to grapple with the issues of performance and conduct in a timely or effective fashion:

Because I wasn't in the HR department, I didn't see people's personal files. How it first came to my attention was when issues were raised through incidents or claims and I would report them, and I would sort of say I think this person – this disciplinary process needs to be commenced. The reaction was always no or we will think about it. At that time we weren't getting any information at the Trust Board about how many people had disciplinary warnings on record. At a later stage the information started to come through and it was very, very low. I also began to notice when people would come to me and say: we want to part company with so and so, because they are not performing or they have been off sick for a long, long time; and I would think: what have you got on record? And there would be nothing.

102. In addition to the experience of patients and their families, the experience of staff who have raised concerns about colleagues suggests that Trust management appeared more keen to protect the subject of the concern rather than the informant. In the section on whistleblowing, I record a case in which a nurse reported the pressure applied by two nurses in A&E to have records fabricated in order to show compliance with the waiting time target. The two nurses against whom the complaint to this effect had been made were eventually reinstated to

A&E without any regard being paid to the effect of this on the informant, who has subsequently left the Trust. According to her, the manager who made that decision said:

... that these two sisters were coming back into the department because in their absence, the breach times had gone through the roof and that these two were clearly the only two sisters who could run the department effectively and efficiently.

103. This must inevitably have led to the impression that the unacceptable practice of which they had been accused was condoned.

104. Nurses who were subject to extremely serious allegations of pressuring a colleague to fabricate a medical record have been allowed to return to duty in the same area, A&E, with little clarity as to what findings or actions have been taken about the allegations. It appears from correspondence to the sisters that the allegations were neither *'proved or disproved'*; however, this did not appear to be communicated to the staff of A&E, nor has the investigation report been disclosed to the Inquiry. The impression I have is that a thorough and rigorous inquiry into the matter is unlikely to have taken place. The message likely to be received by staff is that such behaviour is not taken very seriously, and certainly not as seriously as the need to meet targets.

105. The Inquiry has also looked at the Trust's reaction to a serious untoward incident (SUI) occurring on 24 March 2009. This is dealt with in detail in the section on clinical governance (below). The SUI concerned a very serious allegation of a departure from acceptable practice leading to the death of a patient. Two critical, but not independent, review reports followed and a review panel was held in August 2009, which concluded that anal surgery should cease at the Stafford and requested that the Royal College review the surgical division (the second such review in two years). The resulting report is damning and, among other things, recommended that the conduct of the relevant surgeon, among others, should be reviewed. In response, an agreed restriction of practice has been imposed on the surgeon, but only in January 2010, some 10 months after the fatality. It is not for this Inquiry to determine whether the serious issues of concern about the surgeon are justified, and he has denied them forcibly, but I consider that the public have been exposed to an unacceptable risk by allowing a practitioner subject to such allegations to remain in unrestricted and unsupervised practice for such a long period, while there has been no substantial determination of the matter. This suggests to me a laxity and tolerance of such allegations that has no place in a modern hospital.

Reliance on external assessments

106. A feature of the evidence I heard from former directors of the Trust was their reliance on external assessments of the Trust's performance to provide them with reassurance that it in fact was performing well, as opposed to reference to internal governance systems or even their own observation and inquiry. Whatever may be said about the failure of external agencies to detect the gravity of the problems facing the Trust earlier than in fact happened, any such criticism, even if merited, cannot derogate from the responsibility of Trust management to satisfy itself that a good standard of performance is being reached. Yet this was not the position of some significant witnesses.

107. Ms Brisby, the former Chair of the Trust, was asked about passages in the Trust's application for FT status which asserted that a high standard of care was being delivered, and the basis for such assertions. Her answer revealed an emphatic reliance on external assessment:

The clinical side of the Trust's activities, and responsibility determining whether that's up to standard or not, rests with a whole bunch of organisations, most significant of which is the Healthcare Commission. ***So it is not as if we were saying our services are fine. It is more there is external assurance of the fact that you have reached the standard in terms of service provision.*** [Emphasis added.]

Q: *Forgive me. Whether or not outside bodies have that positive view or at least a non-negative view of your activities, surely the principal responsibility for knowing whether or not the standards are good rest with the Board?*

A: *I think so. The information we were getting – that is undoubtedly true. I guess what I said was just to reinforce that point. The information we were getting was suggesting that we were doing okay. We weren't doing brilliantly but we were doing okay.*

Q: *But isn't it rather dangerous for all sorts of reasons to rely overmuch on what outsiders are saying about you, as opposed to what you know yourself, because you ought to know more than the outsiders?*

A: *I think you need both, actually.*

Q: *That is not quite the question. You need to know more, don't you, than the outsiders?*

A: *Yes. Of course.*

108. Later she was asked:

Q: *In a sense, back to the Chairman's point, you saw the fact that the Healthcare Commission had assessed you as being in a position to apply for foundation trust status as conformation of the Trust providing good or satisfactory standard of service?*

A: *Yes. I am absolutely certain that if we had got the sense that was not the case and the Healthcare Commission had got it wrong, and actually we were providing a really poor standard of service, then that would have been a very different sort of discussion.*

109. A similar view was expressed by a non-executive director, Mr Carder:

I was not getting anything from complaints, contact with the PCT or anything like that which was telling me otherwise. So I had no particular basis to challenge the assertions of the executives because most of the news we were getting was good news.

110. He was asked about the effect of the FT application:

Q: *We can see from the application itself that the Trust is presenting itself in a very good light indeed.*

A: *Yes.*

Q: *Suggesting that it is providing a first-rate service to patients, so I am talking now at the application stage, July 2007. What basis did you and your fellow non-executives have for understanding those sorts of assertions to be correct?*

A: *I guess that was assurances from the executive directors and the various bodies that monitor the hospital. At the end of the day assertions are one thing. My view was you have to go through the process. The process will test those assertions.*

111. Another non-executive director was clearly perplexed at what had happened:

I thought about it long and hard over the last nine months or so and I suppose the thing I can't quite come to terms with is the fact that we have been so heavily scrutinised, both through the foundation trust process, before the foundation trust process, by many organisations. As I have said before, we take assurance from many different areas, including our own personal experiences and those of our families, friends, acquaintances and whatever, and I still to this day do not understand why we were not aware of these issues and I find it astonishing that nothing was said to us; that none of these investigating or scrutinising bodies found even a glimmer of evidence of these issues; that in our informal contacts with doctors and nurses round the hospital, that nobody

ever said anything about these issues. I just find it astonishing and I have no explanation for it.

112. Dr Wall, another non-executive director, with a medical background, also relied on external agencies as justifying the assertions made about the quality of care in the FT application:

There is clearly a positive basis for making that assertion, and I think it is the evidence that we had, and this really is the nub of what I wanted to get to today, which is that we as a board took clinical issues, the whole issue of care, very, very seriously. We got most of our assurances from – we got our assurances from a variety of sources, from internally within the Trust but also from external sources, from various external inspectorates, whatever. So we had inspections by the Royal Colleges, we had inspections by patient groups, we had inspections by... local authority scrutiny committee. We had inspections by the breast cancer screening team from the West Midlands and it was – they weren't all perfect by any means, but generally speaking the picture that was emerging was very positive. By and large that is where we took – that is how we get our assurances, and I think that is how we felt confident that we were able to provide, if not a good clinical service, at least a reasonable clinical service.

113. There are a number of reasons why this reliance on the views and assessments of external agencies is no substitute for proper internal governance and audit systems and for directors, both executive and non-executive, taking personal responsibility for finding out how the organisation is performing:

- Much of the data on which external assessments are made is created by the Trust and therefore the assessments are as accurate or inaccurate as that information.
- If effective governance is absent, there is no means of ensuring that the data supplied, either externally to regulators and others or internally to the Board, is a reliable measure of performance.
- Many of the performance indicators used by external bodies are insufficiently focused to pick up deficiencies in basic care.
- External agencies have a tendency to assess systems and processes rather than outcomes or the nature and standards of care being provided.
- No statistical data can ever be a complete substitute for direct engagement with patients, their families and staff, or for direct observation of what is being done at the front line of the service.

114. Mr Sumara, when asked to comment on the advisability of relying on external agencies in this way, was blunt:

Well, I do not see how – first of all, it's a deflection of their duty, isn't it, because it is their job to run the hospital, not Monitor. As I said to you before, now that Dr Foster said we are in the top 10, I can go home now, could I, because they have said we are okay? Well, life is not like that, is it? It is my responsibility to make sure that the hospital is safe; it is my responsibility and the Board's to make sure that the care is good. Just because somebody outside is saying it is okay, that is not – I would be giving away my duties. I think first of all it is not their job to say: somebody else told me it is okay; therefore it is okay. It is their job to get assurance internally to do that. I think the second bit is, I am not aware of any external body, regulator that has that sort of capability and certainly foundation trust process wouldn't give you any assurance about the quality of patient care and safety. In fact I think Monitor are just now trying to build up that expertise.

115. Sir Stephen Moss pointed to the importance of listening to patients and of realising the significance of any inconsistency between what they were saying and the data:

I think the thing that, from talking to people and looking back at Board minutes myself, I think one of the key things they weren't doing was making the connection between feedback from national bodies and the local intelligence that they were picking up. In other words, you could get a national body saying one thing, but then if your patients and their families were saying something different that would lead you to think actually it is not like that, that didn't seem to get the focus that the national reports would tell them. So there was something about, in looking at what the Board looked at, it did not make that connection from what I could see.

116. Later he added, in relation to the recent apparent improvement in mortality data:

... if it doesn't feel like it when you are working there, then there is a damn good reason to say: hang on a minute, let's really get underneath this, because this doesn't feel right. It would be lovely to sit back and say: aren't we wonderful to go out there shouting about how things have got better; but if it doesn't feel like [it], then you do something that actually gets underneath that.

117. I respectfully agree with the views expressed in this regard by Mr Sumara and Sir Stephen. Approbation by external regulators is no substitute for direct knowledge of what is actually being done within a trust. The first is at least in part a matter of image, the latter of substance.

Denial

118. It is striking that in the face of a highly critical HCC report, and the Colin-Thomé and Alberti reviews, so many former directors, senior managers and other staff appear to be unable to accept that the service provided by the Trust has been

as bad as has been portrayed. This denial takes a number of forms. One group suggests that complaints may have been exaggerated or inaccurate. Some rely on their belief that there is much good practice at Stafford. Yet others believe the investigation or the report to have been unfair. Most resent the nature of the media reporting.

119. The material collected by this Inquiry should put paid to the suggestion that sufficient of the complaints made by patients and their families are exaggerated or inaccurate, to allow the conclusion that there were serious generic problems to be dismissed. I am simply unable to accept that the accounts I have been given at the oral hearings and the bulk of the written material I have received, and which is summarised in Volume 2 of this report, present anything other than the substantive truth. Much of the substance of the complaints I listened to had already been accepted as justified by the Trust after investigation, and in any event all the patient and family witnesses I saw were impressive in their own ways and presented a highly persuasive overall picture. These were not people with imagined, let alone fabricated, grievances. I can only suggest that any remaining sceptics read this report in full and then ask themselves whether they can maintain that position.

120. Those that say there is good practice in Stafford are correct. Witnesses have singled out various areas and individuals for praise, and rightly so in my view. For example, it appeared to me that the critical care unit was particularly well run. Various nurses have been praised for their dedication in some of the evidence that has been cited. However, no amount of good practice can disguise or excuse the deficiencies in service provision that have been identified. These cannot be brushed off as isolated incidents attributable to the sort of lapse that can occur in any well run hospital.

121. It is fair to comment that the HCC report did not reflect much, if any, of the staff experience, and it is to be hoped that this report redresses that balance – as my terms of reference required. However, if anything, I consider that the HCC report understated the level of concern that it is appropriate to express. The HCC appears to have looked at significantly fewer patient complaints than has this Inquiry. This Inquiry has revealed nothing to suggest that the HCC exaggerated the cause for concern at this Trust, despite the comments of one of the NEDS that the report was *"unbalanced"* and the view of the former Chair that the evidence base for the HCC's findings was *"dubious"* .

122. The directors who were in post during the period under review have been equivocal in their acceptance of the criticisms that have been made previously.

123. In a written statement to the Inquiry, Ms Brisby, the former Chair, said:

... if the Inquiry should reveal that the care provided in your hospital fell short, then the people affected and their families have my deepest concern and sympathy.

124. When asked whether she accepted that there had been a failure to provide basic nursing care over a protracted period in a number of areas, but in particular in Wards 6, 7, 8, 10, 11 and 12, A&E and the emergency assessment unit, she said:

Can I not start there and answer that question differently, which is that I have a lot more confidence in this process than I had in the Healthcare Commission process. Which I think raised a lot more questions than it actually answered. Which was part of the reason for the "if". It was sort of if you find, then et cetera. I think the Healthcare Commission process, for reasons I am quite happy to go into, was very unsatisfactory. I am absolutely certain there were examples of really poor nursing care. I have no doubt at all about that. I am deeply sorry about it. I don't have any confidence in the Healthcare Commission report, which makes it difficult to judge just how far and how long that lasted, but in a sense that is not – that is only a part of the point. I think if people have poor nursing care, they have poor nursing care and there is no excuse for it. I would not attempt to justify it.

125. She then argued that the patients and families who had come forward to the Inquiry were *"sort of a self-selected group"* and that they were not representative. At the same time she did not seek to challenge the veracity of the accounts the Inquiry had received, and volunteered that the care described was *"unforgiveable"*. Her point about such care was that the Board had been unaware of it. Her retrospective reasons for this lack of awareness were, firstly, that until the staffing review by Helen Moss, the Board had been unaware there was an issue of staff shortage; secondly, that they may not as a Board have been close enough to the patients; and thirdly, that they did not deal with complaints in a sufficiently *"granular"* way. She considered that the effect of the publicity suggesting that there had been an excessive mortality made the hospital look like one of the worst, which she hoped was not the case:

I suspect having heard those stories is more powerful than anything I might say and I am sure it will be. But the reality is that once a trust is publicised as having killed up to 1,200 people, however mistakenly, then that... stigma advertises it so much that all sorts of things start to surface which wouldn't in a normal hospital. So the process of saying this is a really dreadful hospital, giving appalling care, has a knock-on effect immediately and skews things. I am genuinely, genuinely not defending bad care. I am really not. I think if any hospital in the country treats people badly from time to time. It could be that we are worse than most. I seriously hope that is not the case but it could be. But there are often two sides to quite a lot of stories.

126. Regrettably the impression left by Ms Brisby's evidence is that, while she genuinely regrets that such incidents of poor care have occurred, she has been unable to accept the enormity of the problems that engulfed the hospital and, in spite of being given the opportunity to do so, did not appear to accept the Board's responsibility for what went wrong. Such a position, held in the teeth of external adverse opinion, suggests an entrenched attitude of denial and dissociation from the issues that beset the hospital and its patients.

127. Ms Brisby was not alone in displaying this sort of approach to what had happened. Mr Sumara, the current Chief Executive, described the impression he formed about attitudes within the organisation when he arrived. This echoes Ms Brisby's position at this Inquiry:

First of all, an overwhelming sense of denial in the organisation, characterised by "It's not our fault, it is somebody else's", it is the PCT or the department or the Healthcare Commission or whoever else was around that you could blame for how awful it is.

Then the second overwhelming impression that everywhere else is probably the same but they just have never been caught. Both completely outrageous remarks repeated by several sometimes quite senior individuals in the organisation, which are just wrong. They are just at that state of denial.

128. The current Medical Director, Dr Obhrai, found a similar attitude when he attended his first Board meeting in March 2009:

That was the overwhelming feeling of denial, that there wasn't acknowledgement that things were going wrong that they needed to be put right. I think [Sir Stephen Moss] *joined a month or so before. At the Board meeting we both attended as observers because we hadn't started, yet it was obvious that certain clinical matters were left right at the end, like a serious event that was discussed right at the end of a three and a half hour meeting and all the other agenda items were nothing to do with patient care. That was the overwhelming feeling that the critical care wasn't the total focus. As* [Anthony Sumara] *said, that is what the hospital is for, to treat patients. That is all there is to it.*

129. The non-executive directors who gave evidence contested the HCC findings. When asked to explain how they were able to sign a declaration to Monitor in support of the application for FT status that the Trust was providing *"a very good quality of care"*, Dr Wall, a director with a background of being a consultant in public health, disputed the suggestion that they had got it wrong:

If it was – that is the point. I think we would dispute that it was wrong.

130. When he was referred to the HCC findings he replied:

Well, the Healthcare Commission certainly pointed – nobody is denying that there were failures of care at times in certain areas. We wouldn't deny that at all. My big issue with the Healthcare Commission report is that it gives the impression that there were systemic – systematic failures, which I don't believe and that it was, if you want, a failing trust and it wasn't a failing trust.

131. Mr Hindley, another non-executive director, adhered to the position that this had not been a failing trust even after taking into account their shock at listening to the stories told by Mrs Julie Bailey and Cure the NHS members at a governors' meeting:

I have vivid recollections of a very early meeting of the new board of governors when Mrs Bailey and a number of her colleagues attended. That was the most harrowing experience I think I have ever been through and all of us were there.

Mr Bell: *Yes.*

Mr Hindley: *I will be quite open and honest about it, I had no idea about the magnitude of the problem before that meeting, but by hell did I when I left that meeting. It was harrowing. But to project that and say that the whole of the organisation was failing, I think is a gross overstatement.*

132. When pressed on whether he acknowledged there had been systemic failings, but not throughout the hospital:

Q: *Your point would be that it is unfair to tar the entire hospital with the brush of bits that have gone wrong?*

A: *Yes, and that has put it very well. That has put it very well. These were serious failings, I fully acknowledge that. If we would have been aware of these, my gosh, if we would have been aware at the time, we would have been horrified and we would have done something about it. We weren't aware at the time. But I am concerned that the Healthcare Commission report, I do not think it actually uses the phrase "failing hospital" or "failing trust", but it certainly gives that impression and it was not a failing trust.*

133. Mr Sumara's recent comment to me, during the closing session, strikes an appropriately different tone:

I have no doubts that the failure at Mid Staffordshire NHS Foundation Trust was real, serial and had a devastating impact on the way patients were cared for. As an NHS professional, I would want to apologise for that.

134. This reluctance to accept the scale of the problem or the responsibility for it extended to lower echelons of the organisation. One witness, trying to find out about her husband's care, said: *"It was really hard to tie anybody down, to find anybody, to ask questions of;* another patient spoke of an *"incurable inertia" and* of a ward without routine or discipline; a third said that phone calls were never answered: *"They would say: we will come back to you tomorrow; but tomorrow never appeared."*

Comments

135. Clearly not all management and staff have adopted the attitudes and negative culture described in this chapter, but sufficient have, to lead me to conclude that such a culture has played a significant part in the development of the problems to be seen in this Trust. This culture is characterised by introspection, lack of insight or sufficient self-criticism, rejection of external criticism, reliance on external praise and, above all, fear. I found evidence of the negative impact of fear, particularly of losing a job, from top to bottom of this organisation. Regrettably, some of the causes of that fear have arrived at the door of the Trust from elsewhere in the NHS organisation in the form of financial pressures and fiercely promoted targets.

136. Such a culture does not develop overnight but is a symptom of a long-standing lack of positive and effective direction at all levels This is not something that it is possible to change overnight either, but will require determined and inspirational leadership over a sustained period of time from within the Trust.

Section C
The experiences and perceptions of staff

Introduction

1. So far this report has looked at the experiences of patients and their families, and the prevailing cultures of the organisation through the eyes of staff, management as well as hospital users. I now consider the experiences and perceptions of staff working at Stafford, which helps to establish what went wrong on the wards and led to such significant deficiencies in care for patients.

2. It has already been remarked that disappointingly few members of staff came forward to the Inquiry with their experiences: some of the reasons for that have been examined in previous chapters. However, thanks to those who have helped the Inquiry, together with my encounters with a wide range of staff at meetings in the hospital, and some private meetings with individuals, I have been given a picture which I am satisfied is a fair one. A number of points have emerged from what I have learned:

    - The accounts given by staff of their experiences at work strongly confirm the impression given by the evidence of patients and their relatives that there was a pattern of substandard service delivery, as opposed to a series of isolated incidents.
    - While some of this was due to unprofessional behaviour on the part of individuals, the overwhelmingly prevalent factors were a lack of staff, both in terms of absolute numbers and appropriate skills, and a lack of good leadership.
    - Many staff members did raise concerns, individually and collectively, but none experienced a satisfactory response. This discouraged persistent reporting of concerns. In the case of the medical staff, many appear to have been disengaged from the management process, as seen above in the section on the culture of the Trust.
    - There was an acceptance of standards of care, probably through habituation, that should not have been tolerated.

Accident and emergency (A&E)

3. The HCC report found many deficiencies in A&E.[24] These included: inadequate medical and nursing staffing, leadership and training; inappropriate use of the clinical decisions unit: the priority given to targets; and inadequate governance. Nothing found in this Inquiry raised any cause to question these findings.

4. A clinician, who came to the Trust and A&E as a junior doctor in October 2007 and who is now a consultant there, was disturbed by what he found and had no issue with the HCC findings:

[24] Healthcare Commission (March 2009) *Investigation into Mid Staffordshire NHS Foundation Trust*, p. 124

When I came to the department, I was more than surprised at the level of care that we regarded as being acceptable for an emergency department.... The way in which we structured our care and in particular the battle-fatigued attitude of the staff did not lead to – it wasn't conducive for good quality care. It was a case of getting through the day rather than how good can we be today?

5. The Directorate Manager of Emergency Medicine, who arrived in November 2007, found a sense of chaos and a lack of reflection about what might be the fundamental problems:

   It was a little chaotic as patients had got to walk right through various areas to get to ... bits of the department. So there were queues of ambulances, staffing, there were only two or three nurses that I could see at that particular time. The board was full of patients waiting to be seen and patients waiting to be moved off to the ward. When I asked what was happening with these patients and why they were waiting, the response was; we haven't got enough beds or we are waiting for beds to become available... I remember one of my questions to this person that showed me around was, given the opportunity, what would be the one thing that they would change within the A&E department and the response was how they care for patients that they receive from the prisons. And in amongst all the chaos, I found that quite a strange answer because I am thinking, this is pandemonium and you are concerned about patients that we get from the prisons. So they clearly hadn't got an indication of the ingrained problems that were there because then they were not involved on a day-to-day basis.

6. Staff had concerns about the effect of constant changes in management structure, and also what was perceived to be the lack of clinical leadership within the department. Between 2002 and 2007, the department was moved to different directorates three times, and four different managers were appointed. This led to a lack of effective leadership and a feeling among staff that concerns had to be repeated continually without anything being done about them:

7. A senior consultant told me:

   We would be going to directorate meetings; the same things would be on the agenda all the time. We would maybe feel that we were starting to make some progress and then we would be in another directorate and we would go back to base point again....

   Q: *I just want to get a feel for the nature of the relationship which you had with the managers.... could you, for example, and did you go to them and raise your concerns about the shortage of nurses?*

A: *Yes. And I think we wrote papers for three directorates, indicating what we needed to provide a safe complement.*

8. The same consultant remarked that senior management were rarely seen on the front line unless escorting a visitor.

9. The Directorate Manager, referred to above, found that equipment and refurbishment shortages were not adequately addressed because of weak management:

   There were lots of interim managers, one of the interim managers had been asked to develop the business case for the refurbishment of the department. However, because of the naivety of that particular manager the department had expanded by several bed space ... but they had not ordered trolleys to go in the bed spaces so there were no trolleys. Simple things like when you are doing your business case, it is not only about the money [or] *staff but what equipment you are going to need to fill your brand new department and simple things like all the doors had been taken off the cubicles because nobody had said it was an infection control issue.*

10. There was a feeling that both the medical and nursing staff in the department received inadequate leadership and support. One consultant told me:

    I got no sense that the nurses had any protection whatsoever. I felt that nurses were hung out within the department and they were not – this is the period of time when I was there – they were not supported...

11. A nurse felt similarly:

    Q: *...Did you feel that you were having support from the nursing leadership within the hospital?*

    A: *No. We didn't. We didn't at that time – initially we didn't have a matron which we do now, although the role of matron is sometimes unclear. We didn't have a senior sister, a band 7, as they are called now, who was our direct lead in management.*

12. Another consultant confirmed the lack of support for nurses and doctors:

    A: *...the leadership in the department was not good and that reflected on some of the care that was provided to some of the patients.*

    Q: *By leadership in the department, you are referring to leadership amongst the doctors?*

    A: *Both nurses and doctors.*

13. The view that there was weak clinical leadership was unfair to one senior consultant who was at work in the department during much of the period under review. This consultant was described as *"ineffectual"* by the Directorate Manager quoted above, and as having *"leadership difficulties"* by the junior consultant also mentioned above. While this was so, it is clear from the evidence received at this Inquiry, including from the consultant himself, that he had been placed in an impossible position over a sustained period. In 2002, there were only two consultants in A&E, and an associate specialist. An additional post was created, but the consultant whose leadership skills have been criticised told me that this was insufficient:

    Q: *Were three consultants sufficient numbers to cover the workload of the A&E department, would you say?*

    A: *No, I wouldn't have said so. The 1 in 3 rota, with being in on Saturday and Sunday for a shift on the floor, was really quite strenuous. If you wanted to take two weeks' leave, you couldn't get a two-week block in which you had a weekend before and after, and that made that particular rota quite stressful and when we were on call, if we had been called in, if you came in you may be in for an hour, hour and a half, and if that happened on a Saturday, Sunday night, then to get up to come in and work the shift on a Sunday with still being on call until 9.00am on the Monday morning, it could at times be very exhausting and tiring.*

14. One of the consultants died suddenly in September 2005, leaving two consultants and the associate specialist, who stepped into the consultant position on the rota. Even this level of consultant provision was reduced as a result of the associate specialist taking voluntary redundancy in October 2006, after which the department remained staffed by only two consultants until March 2008, when one of them left, leaving the survivor dependent on locums for support. Faced with the prospect of a 1 in 2 rota, the senior consultant expressed his concern to divisional level management but was *"ignored"*. He devised a rota whereby the two remaining consultants covered the *"shop floor"* from 9.00am to 9.00pm, Monday to Friday, and took one weekend in three. The third weekend was covered by an associate specialist in general medicine (later to become a consultant in emergency medicine).

15. This level of staffing was clearly insufficient. In his review in April 2009, Professor Sir George Alberti[25] recommended that A&E should have six consultants. The senior consultant himself, when asked by the Inquiry, thought this was *"about right"*.

[25] Professor Sir George Alberti (29 April 2009) *Mid Staffordshire NHS Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report*

16. By March 2008, three emergency physicians had been recruited, but as physicians trained in internal medicine they did not have the expertise to address all A&E needs such as gynaecology, paediatrics, suturing wounds and intubations of patients with life-threatening conditions.

17. Asked for her reaction to the lack of A&E (as opposed to emergency physician) consultant cover at night, the Directorate Manager said it was *"very scary I have to say, thinking, oh my God"*.

18. The senior consultant in his statement to the Inquiry described the A&E department as *"not a safe place to treat patients"* over a four-year period. He did not challenge others' description of himself as not providing leadership, but pointed out that he had been suffering from depression for some time; he attributed this to the stress of the job. As a result of this, he had been off work for two periods in 2005 and 2006, and a further extended period in 2008/09. He remains off clinical duties.

19. Therefore, the true picture is not one of weak leadership being provided by a particular consultant, but of a system that may well have ground down a conscientious practitioner into a seriously pressurised man, and of a management failure to ensure proper support for clinical staff to enable good leadership to be provided.

20. One consequence of this is lack of leadership and consultant presence would have been inadequate support to junior medical staff.

21. There was a strong view that there were inadequate numbers of nurses. The doctor, mentioned above who arrived in A&E in October 2007, did not accept that the problem was due to the quality of the staff, but maintained it was due to a staff shortage and the system within which they were obliged to work, leading them to put their heads down and get on as best they could:

    Absolutely not about the quality... You have large numbers of staff, you have good ones and bad ones and you try to make the bad ones better. The problem was primarily that there just were not enough staff... Nobody comes to work, very few people come to work to do a bad job and I have never met a nurse who comes to work to do a bad job. 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. And the system in the hospital said no to the nursing staff doing the best they could and to the doctors, but I think the nursing staff probably feel that more acutely in certain respects.

22. The senior consultant agreed:

Since I started in Stafford [in December 2002], *I have always been aware that we do not have enough nurses to run the department safely.*

23. The Directorate Manager, who started at the Trust in November 2007, observed:

In A&E, when I eventually started at the Trust, the A&E was the brand new department as it is now and it had been refurbished, but because of the layout of the department, occasionally when I started, there would be five or six nurses on a shift, which clearly, because of the layout of the department and where people had got to be, was not enough.

24. The HCC investigation led it to write to the Trust on 23 May 2008 requiring immediate action to address its findings that:[26]

The department is understaffed in relation to medical and nursing staff

... Insufficient thought was given to equipment...

... there appears to be an almost complete lack of effective governance...

25. There is no doubt that the lack of staff led to the alarming situation found by the HCC in which triage was apparently being provided by unqualified receptionists.[27] I learned that in 2002 triage was deemed less important because of the adoption of a *"see and treat"* policy, whereby patients were seen immediately by a senior clinician. Triage was not done away with, but when subsequent staffing reductions increased pressures on nurses. An advanced nurse practitioner who had been at the Trust for a long time explained:

Triage became the first place to pull the nurse off because it was now considered not as important but we didn't have see and treat in place either. This is the problem. So what happened was the triage nurse was pulled off to deal with the sick patients in the waiting room that were left. That happened more and more frequently and in the end the manager at the time's decision... was that we didn't do triage any more. Therefore the waiting room became full of patients who were not being assessed in any speedy manner at all and they waited regardless of their condition.

[26] Healthcare Commission (March 2009) *Investigation into Mid Staffordshire NHS Foundation Trust*, p. 140-142

[27] Ibid p. 124

26. I was told that while receptionists were not expressly asked to triage patients, they became relied on to make informal decisions. The senior consultant told me:

We could never do triage. We never had someone spare with the right degree of seniority to as an A&E nurse to provide triage. We were relying on receptionists. If somebody had actually made their own way to the department and walked through the door, if they looked unwell, they would then shout for a nurse. The nurse would come up from the department, have a look at the patient. So only when somebody was obviously ill could we actually pick that up. I mean, there could be somebody sitting with chest pain and we wouldn't know they were in the waiting room.

27. And from the advanced nurse practitioner:

The receptionists never actually made clinical decisions on the patient's condition. They didn't assess patients formally, but they were the first people to see the patients, and they did alert the nurses, if they felt patients looked unwell. I accept that is not good.

28. In fact, the new Directorate Manager had been approached to set about changing this, even before she arrived to take up her appointment and before the HCC report, as described by the advanced nurse practitioner:

I actually contacted [her] *before she was in post to say that I wanted to put triage in place. I had been disempowered prior to that but now I felt that I was empowered to do something about it and so I contacted her to say are you happy for me to go forward with myself doing Manchester triage because it is the system that is something that you can introduce quite easily, it is already there, you don't have to train staff in other ways? So I contacted her to say could I have the funding to go and be a trainer, to then introduce Manchester triage and she said well what do you do now? And I said nothing, there is nothing. She said, well, you better do it then. So that is what I did, I went and took a member of staff with me, to Manchester to do the official trainer training and then brought that into the department. This was prior to the Health Care Commission.*

29. The pressure to meet the four-hour waiting target from management, and its observed effect on staff, has been considered in the section on culture above. This had a highly detrimental effect on the standard of care delivered to patients. One nurse described it in this way:

Because of the hurried nature of what was happening, there were times when things that should be done weren't being done because to do so would then encroach upon that time period. So if a patient had not been seen early on in their arrival for whatever reason, and sometimes that would be there was no

room in the department, sometimes that would be because there wasn't enough doctors to get through the patients, then they would get to their being seen time well into their four hours; and this meant to achieve in that time, we weren't able to do it, so things were scrabbled together in the end and patients would be moved either to the emergency assessment unit or medical assessment unit as it was then or to another area before perhaps treatment was started....

Q: *We have certainly heard a lot of evidence from people who have said that the provision of pain relief was delayed in A&E.*[28] *Is that the sort of thing you mean?*

A: *Yes. Or patients who are highlighted to need antibiotics for example, perhaps intravenously, then obviously that is quite time-consuming thing because you get your treatments, you go to get your antibiotics out, you have to mix them, check them and all the rest of it. So if you are on the cusp of a breach and you now know that the doctor has written down this and you have got two lots of antibiotics to give, you are talking quite a delay. So it would be: well, they can have it on the ward. And yes, they would, but it might be two or three hours down the line....*

I was always being told..., this is 24 hour care, we can't do everything in A&E; and whilst I accepted that, I used to feel that that was a good excuse to be whizzing people away before they had their treatment and then they would be waiting maybe two or three hours and we knew that. So it therefore made it wrong.

30. The same witness described the professional dilemma this led to:

We are under the Nursing and Midwifery Council's code of conduct... We are given very firm guidelines about what as nurses we should be doing, and it talks of giving obviously care, acting with integrity and providing a standard of care that is second to none really, as far as we are physically able to do so. So to knowingly send a patient to the ward who you, at this point, know needs treatment that you are not giving so that you can whizz them away, is not right.

31. Asked whether, in view of the professional obligations, she had raised the matter she told me:

It was flagged up to managers on numerous occasions that what we were doing wasn't right. The way round it that I found it for myself personally was I still tried to do those things which, of course, ultimately led to breaches, if I felt that that is what I was going to be doing, that the patient wasn't going to be achieving that.

[28] Some 14 out of 44 cases received by the Inquiry that mentioned pain relief were positively identified as occurring in A&E

Q: *From your point of view, if you acted as you thought was correct from a professional point of view, but the consequence was that there was a breach of the four-hour target, did that have any implications for you personally?*

A: *Yes. Yes.*

Q: *In what sense? You mentioned bullying; did you feel bullied yourself?*

A: *Most definitely, and I was in trouble quite often.*

32. The same witness commented on the absence of a senior sister and the lack of support for nurses:

I tried to pick up things that happened during a shift which... is never straightforward. You can look at numbers and say: there was only 150 through the door yesterday and yet they had X amount of breaches but that is not what it is about in a hospital setting. You can have one patient that for two hours takes three nurses, in a serious position. So therefore those nurses aren't going to be somewhere else. If those things happened it just was not taken into consideration in the way that it should have been, looking at the wider picture.

33. Another example of the detrimental effect of moving patients to avoid breaches of the target was given by one of the advanced nurse practitioners:

I also think that patients were being moved from accident and emergency for whatever reason, to beat the four-hour breach, before they were fully assessed. A good example would be patients who – I can think of an example, perhaps 18 months ago, a patient who came in, very, very ill. Had blood tests done in A&E. I do not think the blood results returned back. He was seen by the basic casualty officer, the most junior doctor. The blood tests were done. As far as I am aware, the blood test results weren't returned for whatever reason. The patient was moved up to the EAU on the four-hour target,... and the patient subsequently had a cardiac arrest. I think what happened was the bloods – if they were back, they were not acted on in A&E before the patient was moved out. The patient needed immediate emergency care intervention to prevent deterioration, the deterioration which of course happened when he appeared on EAU.

34. This witness thought that a much more legitimate target would be to aim for access to a consultant in acute medicine within two hours of admission to A&E, a target which had recently been introduced internally.

35. The pressure is alleged to have led to some staff being complicit in the falsification of records in order to make it look as though the target had been met. In an incident which led to a whistle-blowing report by a nurse, it was alleged that a ward sister had asked her to falsify a patient's records in October 2007. She told me how, owing to a lack of staff to do everything that was required, there was a backlog of patients who had breached the target. She mentioned this to a senior nurse:

I said: just need to tell you that I have come out of triage and found that so many patients have breached, just letting you know. And she said: how long have they breached by? And so I explained the situation and she said: just lie about it.

36. That sister then referred to a colleague who joined in:

She said: just tell her to lie about it, just tell her to write down a lie. Staff Nurse .... came round and she said: did you hear that? And I said: yes, I think so, just tell me again. So she obviously explained that, and I said: I am not prepared to do that; I am not lying about this.

37. According to her, this type of incident was not uncommon:

As long as it was written in the box, and it didn't breach, they wouldn't care who had done it or how they did it. This would often be the case that they would write down: the patient had left at 6.30 but actually they would be in the department until 7 o'clock because they would be receiving treatment and would not leave until much later.

... it has been commonplace for a lot of nurses to do this and to pressurise other junior nurses into doing the same as well.

I had refused to do it and I used to get tutted and moaned about and complained about by other members of staff because I wouldn't do it. If I am being honest, if the breach was literally by 5 or 10 minutes, I probably would. If you were literally just waiting for the porter to arrive back from somewhere before you could physically move somebody out, and it was literally 5 or 10 minutes, I would change it by 5 or 10 minutes, because I thought it is so close there is no need for that to – but anything longer than that and I wouldn't do it.

38. This could even involve altering what a doctor had written:

> [There] *would sometimes be a problem because if a doctor had put down their decision to admit or discharge and their time was after the four hours, how could you then as a nurse write down that they left before that time? But sometimes they would do that. Sometimes they would amend the doctor's writing, change that and below write obviously within the four hours of time that the patient had left. So they would even change the doctor's details and writing.*

39. She suggested that this was something of which doctors were aware:

> Q: *Is this something the consultants were aware of?*
>
> A: *Yes, it went on in front of the consultants. Some of the doctors, especially obviously the junior doctors were encouraged to do it as well, and in fact pressured by certain sisters to do it as well.*

40. This witness furnished the Inquiry with copies of the written statements she had made to the Trust about these matters. The Trust were requested to disclose the external investigator's report, but this, as with other 'whistle-blowing' material, has not been forthcoming,, and no explanation has been offered for this. In the absence of such material, the Inquiry can only proceed on the basis of its assessment of this witness, whom I regarded as convincing in her evidence and the way she gave it. It is an advantage of a non-statutory inquiry that the attendance of witnesses is voluntary. This witness attended voluntarily, and, being no longer employed by the Trust, appeared to have no motivation to do anything other than assist me.

Emergency assessment unit (EAU)

41. The HCC made an unannounced visit to the EAU in February 2008. They made a number of critical findings:[29]

- The environment and layout were not good for patients or staff.
- It was described as *"busy, chaotic and frenetic and as a poor environment for older patients and those with strokes"*.
- It had the lowest score in an infection control audit for 2007/8.
- Capacity was not properly planned.
- The system was ineffective in sending patients to appropriate wards.
- Patients often failed to receive a proper assessment in A&E before transfer.
- There were concerns over the management of surgical and trauma patients.

[29] Healthcare Commission (March 2009) *Investigation into Mid Staffordshire NHS Foundation Trust*, p. 57

42. The Inquiry has received evidence from patients and their families presenting a mixed picture of the EAU. Some of the adverse accounts can be found in the patient experience section above. However, some witnesses formed a high opinion of the quality of care there, including the family of an elderly patient who was admitted to EAU in February 2008. Although they were met with reluctance to allow them to attend their relative to assist with feeding at mealtimes, in general, they considered the EAU nurse to be *"available, and approachable and very kind"*. Another witness described the nursing team caring for her mother in EAU in 2007 as *"exceptional, efficient, kind and caring at all times"*. The wife of yet another patient described being *"impressed"* with the unit. And another thought the staff there *"absolutely marvellous"* in March 2008.

43. However, another family, whose relative was in EAU in April 2008 and who described difficulty in finding anyone to change urine-soaked sheets, told me:

I think the message that you tend to get is the EAU doesn't have the support to actually care for people, and I think again it is the elderly vulnerable, that is the message really. Another patient's relative, while conceding that the standard of cleanliness was *"not too bad"* there, noted that a lot of cotton swabs were left the floor. More seriously, the mother of another family was left on full view completely naked and covered in faeces. The family are more fully quoted in the patient experience section above.

44. The picture presented by staff, however, tended to confirm the impression of those patients and families who had experienced poor care. One nurse described how the unit was known in other parts of the hospital:

I remember at the time when our staffing levels were cut and we were just literally running around. Our ward was known as Beirut from several other wards. I heard it nicknamed that. ITU used to call us Beirut.

45. She described the scene:

I remember saying: this will have repercussions, this can't go on like this. Because relatives were regularly coming up to us and saying: my Mum has been buzzing for this long, there has been a buzzer going there for that long. I do remember Helen Moss coming on to the ward and seemed more concerned with pointing out what needed – like I say, a buzzer needed answering or somebody had a necklace on that she shouldn't have on and it was absolute chaos up there.

46. She regarded the situation at that time as dangerous:

...often, because we had gone down to two nurses, so if for example I was in a side room with a healthcare support worker, there was nobody in my two bays, and patients at risk of falling, obviously there was no one there to watch them. So that was why it was dangerous from a safety point of view.

47. The pressure could be intolerable:

Q: *What is the significance of beds 22 to 36?*

A: *They were the biggest numbers. They were 15. There were two six-bedded bays and two side rooms. Obviously in the side rooms you could have very poorly patients. You could have patients who were dying who perhaps needed a little bit more care. You would have patients who may have C.diff. who could be having their bowels open every five or ten minutes, so you knew when you were working there that you were in for a slog...*

Q: *You say that nurses were often in tears because of not being able to give basic care?*

A: *Yes, many times... we basically could not get to them. We would start at one end of the ward; it is the same doing the observations, the blood pressures and the pulses; and by the time you get to the other end of the ward, there were wet patients sort of back at the beginning where you had started because we physically couldn't do it.*

48. The same nurse echoed the HCC's finding that the layout of the ward made observation difficult because there were patients who could not be seen from the nursing station, and a staff member was not always in that area.

49. This nurse says that she raised her concerns by submitting incident report forms, but she received no acknowledgement:

No acknowledgement, nothing.... Mine were mainly to do with staffing levels; just not being able to give basic care, not being able to get round to feed patients, drugs were later; we could not get to answer buzzers; we could not look after poorly patients and have admission. Just general things that were happening at the time....

50. The principal reaction of line management to such concerns was to suggest that the staff were not good at time management:

Basically our line manager had said that – we knew these cuts were coming, that they were looking to say – that the staff – or the hospital on the whole wouldn't accept that we were going without breaks and that it would [look like] we had poor time management.

51. These concerns were confirmed by the Directorate Manager of Emergency Medicine who arrived at the Trust in November 2007:

The standards of care were minimum, and on occasions, you would – I would have to say below minimum. That then had a detrimental effect on the current staffing that were there because they were constantly working under par. That then had an effect on the sickness levels because you can only work for so long in that situation without having some effect on people's health

52. In her view, a nurse to patient ratio of 1 to 6 was required on this sort of ward, and when she arrived, depending on sickness levels, the ratio was 1 to 8 or 1 to 10.

53. While much of the evidence about the nursing view has come from one witness, confirmation that her view was more widespread came from Mr Carter, the General Secretary of the Royal College of Nursing (RCN). He told me that on his first visit to the hospital he had not visited the EAU, but on a second visit he had:

On my second visit nurses were telling me about it and were saying things like: it was a disaster area, carnage, Beirut, I think somebody said, those kinds of phrases...

54. Clinicians also observed cause for concern in EAU. Typical was the evidence of one consultant who told me that it was "A disaster from day to day."

55. Citing no leadership and a lack of clarity about the responsibility for treating particular patients, he found visiting EAU was difficult:

A very unpleasant experience because you felt exposed, vulnerable, you felt that you could not do your work properly and I said before, if you are a conscientious individual, it is difficult.

56. It is fair to say that there was evidence that improvements were made to EAU. I was told by a consultant in emergency medicine who took over a clinical leadership role in June 2008, that the staffing issues had been tackled by reducing the bed numbers, increasing the nurse to patient ratio, and restructuring the care model so that the unit was looking after acute medical emergency patients. Consultants now see patients for 12.5 to 13 hours a day. As a result, patients are

seen by a consultant within two hours of arriving in the unit if they arrive during the day, and within eight to ten hours otherwise. He considered this to be one of the reasons for the large drop in mortality in the latest Dr Foster statistics.[30] These changes took place in about May 2008. It is possible, therefore, that some of the more complimentary observations made by patients and their families are attributable to these changes.

Other wards

57. The alarming descriptions of the problems experienced on other wards by patients and their families was confirmed by staff who approached the Inquiry. For example, an advanced nurse practitioner whose work took him across the hospital wholly agreed with the accounts of patients and relatives about the difficulty in finding a nurse to talk to:

That would come as absolutely no surprise to me. I can also give some evidence along those lines when I as a practitioner get called to some wards and it is very hard to find a nurse. It still can be. Historically, it is often very hard to find a nurse who knows anything in particular about a patient....

We get calls to see patients and you are lucky sometimes to find the nurse without roaming the ward to find somebody. You often have to read through the medical notes to find out basic information about the patient because the staff sometimes don't know. It is very rare you get someone to help you.

58. The same witness agreed that it was very difficult to find a nurse to accompany a ward round, a problem that he said was still experienced now. A similar point about shortages of nurses was made by other consultants and nurses:

The root cause was there were not enough nurses to start with. That was to do with the cutbacks initially. But then it led to, as it inevitably does with these things, a shift in culture and expectations.

We were aware that there were staffing shortages within those areas [10, 11 and 12] *and that staff were submitting incident reports saying that patient care was compromised because of the levels of staff that they had.*

I do not often go to Ward 10 but certainly 11 and 12 have been chronically understaffed and it is a commonplace to go to those clinic areas and discover that you can't find a nurse anywhere because there are two nurses trying to deal with what six nurses ought to be doing.

[30] See the Mortality Statistics chapter for further consideration of the significance of the statistics

We were using temporary staff, ie trained bank, and it could be a trained or an untrained to replace a trained. So in terms of the quality of care, that was a factor. In terms of the continuity of care, that was a factor.

59. Following the reconfiguration of the wards into floors, the concentration of elderly patients appeared to increase on the medical floor. This created a further challenge for the staff in the provision of good nursing care. Thus a sister from medical floor told me:

Patients who become confused can become very agitated and become very physically strong. We have had windows being smashed in the past, because patients are confused. By the nature of the ward itself, because it is an older age group, we tend to have patients who come in who are confused because they have been dehydrated at home, they live alone at home, they have been dehydrated, they have not been eating properly.

60. A nurse from Ward 10 agreed:

Obviously it is elderly care and because it is elderly care, elderly people, they need a lot of care, they need a lot of understanding, they need feeding a lot of the time and they need everything. They need everything.

61. As did another senior nurse, quoted earlier in the patient experience section:

'On average a third of our patients have dementia.... It can present that they wander; they fall; they are incontinent in [in]*appropriate places'*

62. The reconfiguration also diluted the specialist skills of staff on the second medical floor. The sister in charge said that she tried to keep staff within their area of specialty, and to operate teams for the individual wards that made up the second floor, but that she would often have to move them around *"to make the numbers as safe as they can be"*.

63. This also affected the ability to support doctors on their ward rounds:

...because the doctors come fairly early in the morning, the nurses were unable to abandon what they were doing to accompany them. And they have to decide, sometimes the doctor does training rounds, teaching rounds which could take the whole day and if you are really short on the floor, you are trying to provide basic care, what do you do? The staff on the area make the decision in terms of: do I accompany the doctors or do I provide care and do I provide support to the untrained to make sure that the care is given properly?"

64. Trying to meet these challenges with the resources provided by the Trust was demanding and stressful, and inevitably this exacted a cost on the staff. The nurse who was for a time responsible for managing all the beds on the second medical floor told me that she had been absent for some five weeks with a stress-related illness caused by the pressure of work. She told me that she was working six days a week in an attempt to cover the work load.

65. It is striking how many of the complaints involved the care of elderly patients, which suggests that the Trust did not have the capacity to care for the needs of these people.

66. The same witness confirmed the impression of patients and their families that there was a serious level of under-staffing:

I think in terms of floor 2, it was desperate... I think the problem wouldn't be as bad if the staff I had inherited was all present and working, because the numbers I was given was minimum numbers. So you have no flesh on the bone, you have no extra to play with.

67. The same witness told me how on one occasion in 2005, as an example, she was required to run Ward 10 on her own with a bank healthcare assistant for the whole of a night shift. Following the floor reconfiguration, there was a similar problem on a regular basis, particularly at weekends:

The weekends were quite different because we could not get temporary staff to cover. You could have your figures, your level of staff on duty, if somebody rings in sick, all you need is one person and you are then going back into the unsafe level... It happened fairly regularly. I would not say on a weekly basis, but it happens fairly regularly. Most of the wards – all the wards run on minimum figure level. So there wasn't any pool anywhere. There wasn't somewhere you can ring up and say: hi, can I borrow somebody.

68. It was not therefore surprising that she and other staff described the scene on the ward floors in terms very similar to those used in the graphic accounts given by patients and their relatives:

Especially for 10 and 11 and 12, they have one sluice which is right in the middle of the ward for 11 and 12. You could have buzzers going and unless you are in that particular vicinity, if you are with a patient, you can't just abandon everything to come and see what is going on because the patient you are with may be unsafe, may be at risk of falling down. If you are in the middle of cleaning a patient, you could not just say: I am sorry, I will come back to you later because the patient has the right to have your full attention.

69. Another nurse told me of her experience in understandably emotional terms:

They [the patients] *needed a lot of medical treatment, drug treatment, blood transfusions, blood products which needed registered nurses, but as a registered nurse on there, you would have to be there to do that side of nursing as well as being on the shop floor, as it was, because of the nature of their illnesses meant that they were given laxatives basically to clear them. So you had to basically clear them up because a lot of them were incontinent.*

Q: *Is that something that you felt there was sufficient nurses to do that efficiently?*

A: *No, no because I felt that I would have to be in about ten places at once. Because both sides, like the medical side, the drugs side, the blood transfusions, the basic nursing care, they are both important for a person... I mean in some ways I feel ashamed because I have worked there and I can tell you that I have done my best, and sometimes you go home and you are really upset because you can't say that you have done anything to help. You feel like you have not – although you have answered buzzers, you have provided the medical care but it never seemed to be enough. There was not enough staff to deal with the type of patient that you needed to deal with, to provide everything that a patient would need. You were doing – you were just skimming the surface and that is not how I was trained.*

70. The under-staffing and its effects were such that some members of staff realised their professional registration could be at risk. One nurse told me:

I had a four-bedded acute unit that was meant to be staffed with one trained nurse in that four-bedded bay all the time... To actually then reduce the area from... but let's just say from four trained a shift down to two trained... there is no way that you could put a trained in for four patients and one trained for the other two parts of the ward. Anybody with common sense would know that it doesn't work because the one trained nurse would think, I can't do it. It is not safe. Her registration is at risk.

Q: Is it that serious? So not safe and you think registration of nurses at risk?

A: Yes. It wasn't safe

71. The surgical floor also suffered problems caused by the reconfiguration. These were very apparent to the clinicians whose patients were cared for there. In particular, the combination of vascular and colorectal patients was clinically inappropriate, caused a concentration of high dependency patients in one place and diluted the availability of nursing staff experienced in the particular needs of each group.

72. A senior nurse and RCN representative told me:

Colorectal is dirty surgery by the very nature of the surgery, and vascular surgery needs to be very, very, very clean because you have patients who are having amputations. They have very big wounds. They have major surgery, aortofemoral bypass grafts. Grafts need to be absolutely strictly kept clean. So to us clinical nurses, it seemed a bit of a nonsense.

73. As with the medical floors, there was a problem with regard to the dilution of specialist skills and the familiarity of nurses with the requirements of different consultants. This was reflected in a reduction in the frequency of contact between surgeons and particular nurses, leading to communication issues. A senior consultant told me:

Inevitably, if you are used to dealing with a staff group of, I don't know, 30 and it suddenly becomes a staff group of 60 because you have amalgamated two wards, inevitably it begins to get difficult. I might not be familiar with a nurse... It is certainly highly important to me to know which nurse I am talking to, or to know something of the character of the nurse that I am talking to. By default I think that extends into treatment of the patient. It is a communication thing. One thing that did result from the changes, I am firmly believing of, is that it made communication very much more difficult... there was a time when you could ring the ward and the chances were that the nurse who picked up the phone would know [your] patient. That disappeared.

74. A consultant surgeon complained that there was no division between vascular and colorectal patients:

With the merger both patients were put into one ward, that is Ward 7, and nobody knew the territory where the divide of that into sub-ward, where that is a colorectal sub-area and a vascular sub-area within that ward... So even though there was a colorectal sub-area, vascular nurses would be working in that area, colorectal nurses would be working in the vascular sub-area. So in general there was a total union, total merger over the last few years or so, and nurses felt very uncomfortable. They felt outside their comfort zone. They felt that they were not very happy, there was a lot of unhappiness and felt that they were not doing the best to their patients.

75. Another consultant pointed out the difficulties caused by the concentration of heavy cases in one place:

I think it is worth pointing out that the way hospitals are run is quite different from the old days [when] *it would be a mixed ward of general surgery and you would often have patients coming in with quite straightforward trivial conditions, day cases and overnight stay cases, and that would balance out some of the*

heavy cases because some of the major vascular and colorectal work needs intensive nursing support. You can dilute them if you like on a traditional ward whereas if you concentrate all the vascular and colorectal and put all your high risk cases together, it becomes very intensive.

76. The merger of the day surgery and short stay surgery into one unit also caused difficulties relating to capacity, resulting in the cancellation of operations. As a senior nurse working there commented:

My own particular area, day surgery and short stay, I continued to say that it was wrong and that it wasn't working. We had lots of complaints because patients were being cancelled because you have two different types of surgery competing for the beds. So the surgeons doing the short stay surgery wanted their patients to have beds; the day case surgeons wanted their patients to have beds. When you have 16 beds and there is 33 patients, it is very difficult to make both people happy.

77. The reconfiguration resulted in some combinations of patients for which it is difficult to see any justification. For instance, gynaecology and male urology patients were expected to share the same area. Ms Toni Brisby, former Chair of the Trust, while pointing out that she was not a doctor, agreed that *"this sounds bizarre"*.

78. The effect of the merger of wards was so distressing to nursing staff on Ward 7 that, in January 2009, on the advice of one of the consultants quoted above, they wrote an anonymous letter to the Directorate Manager. It encapsulates many of the concerns raised in this section:

As a ward, despite our exhaustive attempts, we are struggling and on occasions failing to deliver the high standards of care that both ourselves and the Trust aspire to and we request that this be addressed with great urgency... At a recent meeting it was highlighted that our sickness rate was high and the submission of incident forms surpass others. We were asked why. We feel that it is a true reflection of the environment, the unrealistic demands and lack of resources. We all exhausted, mentally and physically. We are fed up with tackling unmanageable workloads, going without breaks, not getting off on time, doing extras with no respite. The environment is neither safe for patients or staff. As registered nurses we are professionally obliged to raise our concerns. We feel compromised, bullied and disempowered. The ward no longer belongs to us. And [on] occasion we almost feel derided.

Comments

79. In summary, the evidence of staff confirms and expands upon the findings of the HCC that during the period under review they suffered a number of serious impediments in the way of providing a good standard of care, which led to an intolerable situation for both patients and staff. These included:

- A&E: the EAU and both the medical and surgical floors were under-staffed.
- There were too few consultants in A&E, leading to inadequate senior clinical coverage and leadership.
- There was a lack of leadership both in terms of ability and staff capacity among nursing staff in all areas.
- The pressure of meeting the waiting time target led to practices which were detrimental to patient care.
- Under-staffing and lack of leadership led to unacceptable stress levels, leading to increased sickness and absence.
- There was a reduction in the availability of skilled and senior nurses.

PATIENT STORY

I heard from the parents of a 20-year-old man who had a serious accident in 2006. He was described with great affection by his parents and friends as fiercely independent, having recently left home and bought a house with his brother. He was close to his siblings and parents and was extremely popular among his peers. His father told me that his son's motto was *"Life is for living and money is for spending."* He told me that his son did just that, earning his money through working extremely hard, and that he loved life.

In April 2006, this 20-year-old man was cycling with a couple of friends when they attempted to go down a steep hill. He went over the handlebars of his bike and the handlebar hit his ribcage. He complained of pain in the ribs and difficulty breathing. He was taken to Stafford Hospital by paramedics where he was seen by a triage nurse who noted that he had severe injuries with a high pain score, recorded as four out of five, and that he had been given morphine by the paramedics en route to the hospital. He waited an hour before being seen and was then taken for X-rays.

His friends recalled that after an hour they were allowed in to be with him, and saw vomit all over the floor; their friend was sweating profusely and holding his stomach in *"horrendous pain"*. He told them he had been taken for X-rays but he had not yet been informed of the findings. He continued to vomit, at which point his friend told him that he would go to find a nurse, but the 20-year-old asked not to be left alone. This was out of character. When he found the nurse, his friend said that she appeared irritated that he was asking questions that she was too busy to answer. He continued to vomit ,and after considerable time a nurse checked on the patient and was shortly followed by a junior doctor, who said that he had just suffered bruised ribs and would be okay. Although he continued to vomit, the nurse provided him with a wheelchair and said he was ready to leave.

His friend asked whether there was any paperwork to complete or medication to take home; she said she was unsure and would go and find out. She returned with a few boxes of tablets and began telling the patient how to take them; however, he was slumped in the chair still holding the kidney dish so his friend insisted that the nurse tell him instead. His friend then helped him into their van and took him home, where he tried to make him comfortable on the sofa before leaving. A short time later, his condition deteriorated and he called 999.

Tragically, on opening the door to the paramedics, he collapsed and died. His spleen had ruptured. This had gone undiagnosed at Stafford Hospital's accident and emergency department (A&E).

Soon afterwards, an inquest was called and the coroner invited the Trust to submit evidence.

A consultant in A&E reviewed the case and produced a report that concluded that the death of their son was *"an avoidable situation" and that "an independent expert will criticise the management afforded to him by the staff ....there is a high probability that the level of care delivered to...* [the patient] *was negligent."*

This report was shared with the parents of the young man for the first time at my Inquiry. It was also revealed that the Trust's solicitor had twice written to the consultant to change the conclusions of the report. She gave the following reason for her actions: *"with a view to avoiding further distress to the family, and adverse publicity, I would wish to avoid stressing possible failures on the part of the trust."*

The report was not sent to the coroner.

On learning about this report, the boy's father said to me: *"It doesn't matter how painful it is for us, because it has always been painful and it always will be painful, but we want the truth and we needed to hear the truth."*

Section D
The management of significant issues

Introduction

1. I now turn to look at the evidence concerning the management of particular issues which led in my view to the deplorable state of affairs which has been revealed. In doing so, I shall largely adopt the analysis proposed by Counsel to the Inquiry in his closing statement. I have read with gratitude the helpful submissions of Counsel on behalf of Cure the NHS and note that they are largely in accord with Mr Morton's. I have drawn freely from both submissions in what follows.

2. The themes which will be considered are:

    - ward reconfiguration;
    - finance; and
    - staff establishment and reduction.

CHAPTER 1
Ward configuration

3. The reorganisation and reconfiguration of the wards into floors is described succinctly and helpfully in the Healthcare Commission (HCC) report:[31]

   Floor one at Stafford Hospital consisted of wards 1 and 2 and the acute coronary unit (ACU). The floor had 44 beds: eight of these were ACU beds and 36 were specialty beds for patients with cardiac, endocrinological and haematological conditions.

   Floor two at Stafford Hospital consisted of 78 beds. The specialties covered were respiratory, gastroenterology, elderly care and stroke. It consisted of wards 10, 11 and 12. There were 38 beds on ward 10, with four of those being for patients with acute stroke; 21 beds for patients with gastroenterology problems on ward 11; and 19 beds for respiratory patients on ward 12.

4. While those who proposed the scheme may deny that the purpose was a reduction in staff and cost saving, that is not how it has been perceived by staff. An advanced nurse practitioner who had the advantage of seeing what was happening on many wards in the course of his duties told me:

   The problem with the clinical floors in my experience was that you tended to have, particularly out of hours, staff a lot more thinly spread across the wards. For example, you would have a ward team that would cover, as I remember, 11 and 12. You would probably have three trained nurses to cover two wards. An absolute minimum would have been four for those two wards. I think for three trained nurses to cover two wards, someone has to float between the two wards and that is not ideal at all. There was a tendency at the time when this appeared, we were thinking that a lot of it was about staffing, about reducing trained members of staff and using this clinical floor umbrella to actually make it legitimate almost; that we could run a couple of wards or even three wards as one area and use less staff to cover it because they could all merge into various jobs. In my humble opinion that was a bad road to go down.

   ... the impression I had was on some wards we would have three trained nurses trying to cover effectively two wards and probably a couple of untrained support staff. In my estimation that is nowhere near enough.

5. It appears that the proposal to reconfigure the wards of the hospital into 'clinical floors' emerged from a visit in 1998 to a hospital in Boston, Massachusetts, by a senior management party, including the then Chief Executive, Mr David O'Neill,

[31] Healthcare Commission (March 2009) *Investigation into Mid Staffordshire NHS Foundation Trust*, p. 61

the Director of Finance, Mr Newsham, and the Director of Clinical Standards, Ms Jan Harry. It is not entirely clear what prompted the idea, but it does seem that among the purposes of the visit was the intention to see if there were ways of introducing cost savings based on the way things were done in America. Dr Gibson, the former Medical Director, did not go on the visit, but sent someone in his place. His recollection was that they went:

... to look at the way the health services were run in the States. I think it probably came out of the fact that David O'Neill had worked abroad for a period of time and therefore was interested in other ways of working and went over to the States to see if there was a way of doing the same job for less money and therefore for efficiently savings... And came back with this idea of medical floors.

6. Mrs Harry denied that the purpose of the proposal was financial, asserting that it was *"revenue neutral"*. She told me that what interested her about the model of care provided in Boston was what she saw as a more effective deployment of skills:

What I saw in Boston was consideration given to the skills and expertise of the staff that were actually deployed in that clinical area, depending on the dependency of the patients at that time, so the staffing would be altered because they may have somebody who would have more skills in that area than another.

7. In a written statement she said that: *"it was a model of care that catered very much for the clinical dependency of the patients".* It was about *"how patients were grouped and the clinical skills based on the dependency of the patients".*

8. It should be noted that a long period elapsed between this visit and the implementation of the floor reconfiguration proposal that it inspired. Whatever may have been the intention at the time the idea was first thought of, I am satisfied that by the time it was approved the attraction of financial savings was a decisive factor. As pointed out by Counsel to the Inquiry in his closing submissions, Mrs Harry's presentation of the proposal to the Trust Board in December 2005 stated that:

The first phase of the clinical floor project will be revenue neutral. The full business case will identify future savings and economies of scale.

9. Sir Stephen Moss, the current Chair, who has a distinguished nursing background, told me:

As I understood it, it was part and parcel of the package of not how we can drive up the quality of care but how we can be more efficient and pull some costs out of the organisation. That is my understanding. Obviously I wasn't around at that time but that is the message that keeps coming back to me.

10. The recorded decisions of the Hospital Management Board (HMB) and the Trust Board suggest that finance was a crucial factor under consideration. At its meeting in January 2006, the HMB considered a presentation on the surgical floor project in which the preferred option was highlighted as offering savings of some £554,000. This was said to come from savings in staff numbers brought about by the scheme. In the paper put to the HMB, one of the purposes of the proposal was said to be to *"deliver savings to support the financial recovery plan"*. The Board considered this proposal on 12 January 2006; the minutes refer to the *"maximum financial savings anticipated"* of £594,000 a year. Mrs Harry maintained her position that the proposal was not driven by finance. She described these savings as *"fortuitous"*. However, it is difficult to imagine the executive team and the Trust Board as a whole not being attracted to it because of the potential savings. She was prepared to accept that if the proposal had involved an increase in the number of nurses it would not have gone through.

11. The HCC report suggests that at the time the proposal to change the medical wards into floors was made, May 2006, a saving of £325,000 was identified out of a total saving of £580,000 from changes generally.[32] Again this suggests a financial imperative as a driver of the changes. As will be seen, this part of the proposal coincided with a drive towards savings in any event.

12. Whatever may have been the original intention, it is certainly acknowledged by all concerned that the scheme was dependent on achieving the right skills and staff mix. Mrs Harry told me:

I would have been very unhappy if the staffing levels were reduced there. I think they would have struggled.

13. She agreed that the ability to provide appropriate care would have been compromised had the right staffing levels not been achieved.

14. There appears to have been no acknowledged evidence base relied on for the proposal other than the observations made by the management team in Boston, where, as was accepted, the hospital visited was operating in an entirely different

[32] Ibid., p. 62

medical environment. Mrs Harry sought assistance from a professor of nursing in the formulation of the scheme for Stafford. I was told that the professor was an expert in educational programmes but had *"experiential expertise"* in the skill mixes required for dependent patients. I did not invite him to assist the Inquiry and therefore it would be unfair to comment on his contribution. In any event, the matters of concern raised by the implementation of this proposal do not depend on whatever his input was.

15. In summary, there were a number of inherent dangers in the proposal to reconfigure the wards in to floors:

- There was a lack of clarity with regard to the advantages to be gained.
- There was no reliance on any evidence base as opposed to impressions formed on one visit to a hospital working in a completely different environment.
- Whatever may have been the original intention, the perceived advantage of financial savings became a powerful driving force in favour of the scheme and this may have encouraged disadvantages to be overlooked.
- The effectiveness of the scheme was dependent on the right skills mix and staff numbers being available, when costs pressures made achieving and maintaining such a mix very challenging.

Implementation of project

16. The scheme was implemented in three separate stages. The first phase was the establishment of the emergency assessment unit (EAU) in August 2004. The second phase was the introduction of the surgical floor following approval by the Board in January 2006. The third phase was the conversion of the medical wards into the medical floors later in 2006. The implementation of each of these phases will now be considered.

EAU

17. In August 2004, a ward was established as the EAU with the intention of building up to 48 beds. It was intended to be a ward into which people could be admitted for a maximum period of 72 hours if it was not clear what their diagnosis was. The idea was to clarify the diagnosis and then admit them to appropriate inpatient care or discharge. It was intended to cater both for patients referred by GPs and those admitted from A&E.

18. The HCC noted that when EAU opened it was intended to have one qualified nurse for every six patients. The Director of Clinical Standards told me that initially there was a good level of staffing on the unit (when it was set up in 2004), a view

also endorsed by the HCC.[33] This was not, however, a view endorsed by many staff. While one nurse at the outset thought staffing was adequate, another nurse reported that in part of the EAU there were in fact three qualified nurses, and three healthcare assistants looking after 27 beds. A nurse also told the Inquiry that staffing was inadequate when she arrived there in the autumn of 2004; she also thought there was a lack of equipment:

... there wasn't enough staff. There were too many beds for the staff [to manage]. *There was not enough equipment at all. Crucial equipment.* [...] *there was supposed to be two monitored bays which* [were to be] *comprised of – four beds on each side, so eight in total for cardiac patients and there wasn't enough monitors* [for the patients]. *There were not enough syringe drivers for giving intravenous drugs and basic things really. It was just really poorly run.*

19. A senior consultant wrote to the EAU manager in August 2006:

Some time ago I told Mrs Harry and [a professor of nursing] *that I did not think that the EAU was staffed to a satisfactory level. I was told that it was and made to feel that I was wrong for having even raised the issue. It is self-evident that there are not enough nurses and that those few that are available are run ragged.*

20. That consultant told me that he had raised the matter previously with Mrs Harry who had not accepted there was a shortage of nurses:

Normally on an EAU, you get very acute patients coming in, so they are stabilised in A&E and then they are moved to an acute area. So the recommendations are really for that type of patient to be nursed appropriately, you should be looking at 1 nurse to 6 patients. They were probably running on, depending on the numbers and the level of sickness, any day between 1 to 8 patients to 1 to 10 patients. So from my point of view and from the nurse in charge point of view, clearly not enough.

21. The HCC report states that at the end of 2007 the nurse-to-patient ratio was closer to 1 to 15.

The surgical floor

22. The HMB considered a paper proposing the amalgamation of the surgical wards into one floor on 3 January 2006. It was called Surgical Floor Business Case and pointed to annual savings of £594,000. It is significant to note that this saving was envisaged as arising out of a reduction in nursing staff. It was suggested that the scheme would allow a reduction of 21.88 whole-time equivalents.

[33] Ibid., p. 57

23. A minute of the HMB records that *"concern was raised about a number of issues"*. These included:

    There is a need to understand the risks associated with these changes and a need to have an Operational Policy and escalation programme on what the Trust does as a consequence of the changes [and that it was] *appropriate to undertake a Risk Assessment.*

24. Mr Yeates is recorded as having asked whether Board members would be happy for the proposal to be taken to the Trust Board *"if all these issues were picked up"*. On that basis, members approved the proposal in principle.

25. This minute makes it clear that a risk assessment would be appropriate in response to some recorded concerns reported to have been raised, and strongly implies that it should be undertaken before the project was submitted to the Trust Board for approval. The Inquiry could find no evidence that any such risk assessment took place. The Director of Clinical Standards, when asked about this, was unsure to what it referred but told me: *"If we had done an operational policy the risk assessment would have been part of that."*

26. That policy, she said, would have been part of the planning of the proposal; and indeed it is referred to in the minutes. However, whatever form of risk assessment had been included in the operational policy, it cannot have been what the HMB was referring to on 3 January: the Board was accepting that there was a further piece of work to do. Mrs Harry said that this was something that would have been done within the directorates.

27. Having been approved by the HMB on 3 January, the surgical floors project went to the Trust Board nine days later on 12 January. It is difficult to believe that the risk assessment referred to at the HMB meeting could have been done by then and no reference is made to it in the Trust Board minutes. Mrs Harry is reported as *"highlighting"* the *"significant staff involvement in the planning stages of the project... including Directorate Managers and Ward Managers"*. It is minuted that the preferred option would:

    - give maximum financial savings (anticipated to be £594,083);
    - improve patient experience and quality of care;
    - meet HIC and other targets;
    - give potential for increased elective surgical activity;
    - denote major organisational change requiring effective HR strategy and support; and
    - highlight risks associated with total reduced bed capacity.

28. It has to be noted not only that the potential cost savings are the first item on this list but that an exact figure is quoted. This adds to the impression that money considerations were at the forefront of this change.

29. Concerns of staff from Ward 14 were reported to this meeting. These were:

- infection control issues;
- the privacy and dignity of patients within mixed-sex ward areas;
- the mix of specialties within the ward area; and
- the possibility of medical patients being temporarily placed in these beds.

30. Mrs Harry is recorded as thanking staff for raising these concerns and gave assurances, in particular that: *"each group* [of patients] *would be cared for by staff with the appropriate skills and competencies."*

31. The Chief Executive, Mr Yeates, is recorded as having welcomed the staff views and giving an assurance that these and other comments would be "*noted*".

32. The non-executive directors, when asked, were unable to point the Inquiry to a risk assessment as such. However, it was recalled that reassurances about the impact of the proposal on staffing were sought from the Director of Clinical Standards, which she gave. Dr Mike Wall told me:

Certainly I was concerned about any staff – impact on staffing and I sought reassurances from Jan Harry, the director of nursing at the time. What I can't remember was whether that was within a board meeting or outside a board meeting. We had lots of both formal and informal meetings. I remember giving her quite a grilling and she – I came away with the impression that she had no concerns at all about the clinical floors project. She was quite an advocate of the project. I think it was her baby in that sense and she certainly gave me the impression that all this could be managed and a change in skill mix achieved and patient care could be improved at the same time.

33. I conclude that whatever risk assessment went into the planning of the project, it was not a process which was at the forefront of the minds of the decision makers. Something which is referred to as needed on 3 January 2006 and not referred to nine days later when the project is approved by the Board, even when staff concerns have been raised, cannot have been accorded any importance at the time.

34. The next HMB meeting was on 6 February. It is recorded that an *"options appraisal for enabling work for clinical floors programme"* was discussed, including the timescale and containing the work at Stafford to avoid opening beds at Cannock. The options were to taken to the consultant staff meeting and

a project plan with timescales, responsibilities and accountabilities was to be brought back to the next HMB meeting. A suggestion was recorded that *"the programme become a standing HMB agenda item".* Far from this happening, an examination of the minutes of HMB meetings in March, April and May disclose no item at all about the floors project.

35. Progress on the floors project was reported to the Trust Board on 2 March, 6 April and 4 May 2006, when it was stated that the current phase was near completion. There was no report of any outcome of the consultant staff meeting, and no follow-up on what had previously been said about risk assessments, or on the concerns raised by staff previously.

36. The process leading to this decision does not seem to have sought or taken significantly into account the views of the real experts, namely the staff who would have to work with the newly configured floor. While the views I heard were perhaps tinged with hindsight, it is difficult to believe that if the staff view of the full nature of what was being proposed, including the staff reductions, had been thoroughly canvassed, the project would not have been modified. I heard from a colorectal surgeon the view that it was:

... a retrograde step and it was something that was talked about at length... It was seen that this was a way of saving money and having generic nurses. There was a pressure at that time to save money... I think it was largely driven through by financial pressures. There was a lot of clinical resistance because it was seen as a retrograde step... I couldn't see any good clinical reason to reconfigure the wards and myself and my colleagues voiced our concerns, but I think it is fair to say they were largely ignored because of the need to make savings.

37. The then Chair of the consultant staff committee told me:

I suppose that probably what the consultant surgeons felt was that these were changes being imposed on them for doctrinaire nursing reasons which didn't have anything to do with how surgery worked or what was the best way to run a surgical team... But it did seem that those changes were – I am sure they were well intentioned but I do not think that they were actually very well thought out in terms of what was going to make surgery more efficient and they were deeply unpopular.

38. A senior nurse told me:

Discussions took place with the director of nursing as part of the [clinical floor implementation group]*... We said we should not be putting colorectal and vascular together, we should not be putting day surgery and short stay together, and we should not be putting ladies' gynae with male urology. It made no commonsense from a clinical perspective.*

39. It is difficult to avoid the conclusion that this project was driven through because it was financially attractive, without adequate consideration of the views of the clinical and nursing staff and without an assessment of the impact and risks to patients being at the forefront of the Board's deliberations about it.

The medical floors

40. The plan was to create three medical floors, one of which was at Cannock Chase Hospital. The floors at Stafford were to comprise 44 beds on the first floor out of Wards 1, 2 and the acute coronary unit (ACU) and 64 beds on the second floor in Wards 10, 11 and 12.

41. The Inquiry has had great difficulty in determining how the decision to make this substantial change to the medical wards was taken. The earliest document the Inquiry has seen that discusses the operational plan for the medical division is dated May 2006 (although this document appears to have gone through several drafts). The document proposed no radical reductions in staff but sought to effect a reverse of the ratio of trained to untrained nursing staff from, broadly speaking 60:40 to 40:60. The Inquiry found a paper and the minutes of the HMB of January 2007 that approved the policy, including the skill mix changes, but could find no record from the minutes of the Trust Board suggesting that this document had been discussed there. Yet there is no doubt that this change in the skill mix did take place.

42. The difficulty in assessing how this important change was made is compounded by a conflict in recollections of or understanding about the responsibilities for leading the changes. The then Chair, Ms Brisby, said that the changes to the medical floors were led by the Director of Clinical Standards, Mrs Harry, who provided assurance to the Board that they would not impact on the hospital's ability to provide good quality care. This was endorsed by the non-executive directors. Mrs Harry herself, however, did not accept this. She told me she could not recall seeing the document just referred to or being consulted about these changes at all, although she would have been expected to have been. She did suggest that there would have been discussion of this at divisional level, as did a matron.

43. Mrs Harry also maintained that if she had been consulted on the change in staff mix she would not have agreed with it:

    [It was a change] *in the wrong direction... I wasn't involved. I will categorically say that if I had been involved, I would certainly have had an opinion... I certainly wouldn't have supported it. Not the staffing levels.*

44. Her recollection was that responsibility for these changes would have been held by the Chief Operating Officer, although the latter disagreed with this, stating that the changes took place before she started in May 2006.

45. A minute of the HMB of 24 April 2006 where the Trust's knowledge and skills framework was discussed, suggests that Mrs Harry must have had some involvement in the change in staff mix:

    Mrs Harry confirmed that clinical care had an actual ratio of qualified staff at a 60/40 split at the present time and it was looking to move towards a 50/50 split and ultimately 40/60 split in the future.

46. When asked about this minute, Mrs Harry said that this referred to a long-term intention, not to an immediate change in ratios.

47. It would have taken disproportionate amounts of resources and time for the Inquiry to have pursued this issue forensically to a conclusion, and it would be unnecessary for its purposes to do so. What is clear is that there is a lack of clarity about how this very important decision was taken, what process was adopted, and the extent to which it was considered by the executive directors of the Trust Board as a whole. While this may be in part due to deficiencies in minute taking and filing of documents, I consider that a failure of collective decision making lies at the heart of the problem. In the absence of any evidence that the full implications of a change in the skill mix on the medical floor were reported to and considered by the Trust Board, I have to conclude that they were not. That there is a lack of clarity as to the executive responsibility is a concern in itself, as is the apparent lack of involvement of the Trust Chair. With regard to the position of the Director of Clinical Standards, there is cause for concern whichever understanding of her role is correct. If she was not fully involved in the process leading to this change, she should have been and should have been sufficiently aware of what was happening to intervene. If she was more involved than she now recollects, then she should have ensured that the matter was fully discussed at the Board, particularly if, as she says, she did not agree with the change in staff provision involved.

48. It is clear is that, as implemented, the general concept of running floors rather than wards met with widespread disapproval. As submitted on behalf of Cure the NHS, a number of senior Trust figures, past and present, attest to this.

49. Ms Brisby, the previous Chair, described it as "*a really bad idea*". Sir Stephen Moss, the current Chair, pointed out that the physical design of the wards exacerbated the problems involved in the scheme:

The three of us [i.e. the current Chief Executive, Medical Director and myself] *have all said that we have never seen such crazy ward designs in our entire NHS careers. So that is a significant factor. When patients say they have not seen a nurse in* [...]*, well, I sometimes don't get surprised because I think the wards are such a weird design.*

50. Dr Obhrai, the current Medical Director, added:

If you extrapolate that and think of saying: we will manage these three wards together as a unit, then you are actually making that problem worse rather than improving it.

51. And Mr Sumara pointed to the adverse medical opinion:

The important thing is there was no engagement by the senior doctors in that system; they hated it.

52. There is strong evidence that the staff did not approve of the change in skill mix at the time.

53. The then Chair of the consultant staff committee was asked:

Q: *... the major change on the medical floors was to switch the ratio of trained to untrained nurses from 60:40 to 40:60. Was that something which your consultant colleagues were concerned about, can you recall?*

A: *Very much so. Very much so.*

Q: *How did they raise that concern?*

A: *I mean, this would have been principally raised through the divisional meetings and perhaps at department meetings. But it was something that was imposed... But there was certainly opposition to the fact that the number of trained staff was going to be reduced. There was also a change in the number of senior nurses around.*

Q: *A reduction I think?*

A: *Yes. That is very serious.*

54. Nursing staff also recollect that concerns about safety were raised:

Q: *One of the things you tell us in the letter you sent to the Inquiry was that this proposal to adjust the split of trained to untrained from 60:40 to 40:60, you say went against the Royal College of Nursing guidelines?*

A: *Absolutely... The Royal College of Nursing states that we should have a 60 registered to unregistered 40 split within any ward and any department, so that you have got more registered nurses to oversee the work that is being undertaken with regards to patient care.*

Q: *Did anybody raise that at the time?*

A: *I think most people did.*

Q: *Did you raise it at the time?*

A: *I did.*

Q: *With whom and in what circumstances?*

A: *With my divisional manager. I was concerned, but her hands were tied and we had to save, I think at the time from the division, it was about £450k.*

55. Even before this proposal there was a view among staff that numbers were insufficient.

56. One nurse wrote in an email to a consultant in April 2005 about Ward 12:

... the situation on ward 12 is such that patient safety is being put at risk because of [a] *shortage of staff. Since ward 12 was designated as the thoracic ward in December 2004 the number of nursing staff for ward 12 has dropped by over a third.*

57. The combined effect of the ward reconfiguration and skill mix review has been a reduction not only in numbers but in the skills available. Staff were concerned about this. An advanced nurse practitioner told me:

I tended to find over the last few years that we have been working more and more with junior nurses who have been in charge of wards, for whatever reason, and I have often found that the skills of those particular nurses have not been up to the mark. So it is a skills issue. An example may be of a staff nurse who is qualified who cannot, for example, work out a simple drip rate, which I have experienced quite a few times. They cannot even work out the drip calculation. It is pretty straightforward. So that would be a concern. That is an example of junior nurses who may even be in charge of wards with very poor skills.

... quite a few nurses – yes, a lot who have been given responsibilities beyond their experience, particularly to do with difficult patients on difficult wards. I feel that this is – this has been – this has carried on over the last few years. We have had junior nurses in charge of junior wards and the standards have dropped.

58. I was given other examples of how this had affected care of surgical patients:

I used to be the night coordinator so I used to rely heavily on these girls because they knew exactly what they were doing, and if they had a sick patient, they would recognise it, they would identify it and they would give you a call and say: I am really worried, this patient is not very well... But we lost all that when we went to the floors, because we had got surgical mixed up with vascular, so you could have a night shift, and you would have Ward 7, which was now floor, 36 beds and you could not have a vascular nurse on all night or you could not have a colorectal nurse on all night. So you have very junior staff looking after people who have no experience in that specific speciality.

59. One result of the floor reconfiguration has been the reduction in senior experienced nurses in charge of wards. It is not clear that the introduction of more matrons has remedied this. Thus I was told:

We have a reduction in the amount of senior nurses who – I am thinking particularly of senior sisters, band 7 posts – every ward used to have a senior sister who was, as opposed to the junior nurses, a role model, an educator, someone to lean on, look up to, respect, who would safeguard standards on her or his particular ward. The junior nurses would know exactly where the line was and they wouldn't cross it with regard to care standards. I think unfortunately in the last five or six years, the removal of many senior nurses of band 7 from particular ward responsibility has had a detrimental effect on not only patient care and standards of care, but also the accountability and responsibility of the junior nurses.

60. The experience of the nurse manager who was for a time in charge of the medical floor was similar:

Part of my concern was to keep the staff with their speciality background. Initially when a floor came into being the staff were redeployed. So some of the staff were being moved... I try to keep the same teams of staff within that particular area. It was at times when there were staffing issues when I have to move the staff around on an ad hoc basis just to make the numbers as safe as they can be... The biggest problem was 11 and 12, when I inherited it, was already being used – was two wards – but being used as one ward area. So the staff was moving between the two specialities.

Comments

61. Professor Hutton suggested to me, and I agree, that the evidence strongly suggests that the whole clinical floors project was planned and implemented without due regard for the staff's legitimate concerns and without monitoring of the scheme once in operation. This would have shown up the deficiencies vividly described by witnesses to the Inquiry.

CHAPTER 2
Finance

62. It is clear that much of management thinking during the period under review was dominated by financial pressures. Even a cursory examination of the Trust Board's minutes discloses that the great majority of time was spent considering finance and the need to balance the books. Ms Brisby told me that the pressure to break even in the NHS is very great:

Breaking even is part of the function of the finance – the role of the finance director and for an NHS trust it is not optional, it is not as though this is something which can be negotiated, it can't.

I can give you an example. On December 22 2005 and it is in my mind because that was the day that we had our first strategic board interview with the strategic health authority to go for foundation trust, and that was conducted by David Nicholson who is currently chair of the NHS and Antony Sumara, who is actually chief executive here now. They were very preoccupied during our board interview and spent a lot of time getting up and going out and taking phone calls and that was because the North Staffs had said that it had refused to break even at the end of the financial year and the entire non-executive team and chair were being removed that afternoon. So those are the consequences. If you don't break even you get removed and somebody that will break even is put in.

63. The Inquiry had the benefit of hearing in detail from Mr Newsham, who had been Director of Finance from 1992 until his retirement at the end of June 2008. From about 1998 he was also Deputy Chief Executive, although he made it clear that he focused on his financial duties throughout. He was regarded by colleagues as being a very good custodian of the Trust's finances and skilful at ensuring that the books balanced. He was relied upon to move funds from one category to another when needed. Ms Brisby described him as someone who:

kept a pretty tight grip both on the way things were run and on information. This sounds very critical it is not intended to be, one of the pressures on finance directors then and now actually is the requirement to break even at the end of the year and the break even at the end of the year means that finance directors have to be quite clever in the way they manage things and I think he was very clever in the way he managed things.

64. On a less positive note, in February 2005 the external auditor from KPMG expressed the view to the Audit Committee that:

There was a culture in the Trust from the very top to the very bottom of the organisation that the Finance Director would look after the finance and it was not their problem.

65. The Trust had been facing financial problems for some time before the period under review. After more or less breaking even in the years 2001/02 and 2002/03, it suffered a deficit in the region of £500,000 in 2003/04. In order to balance the books, the Trust took a loan (termed 'brokerage' in the NHS) from the strategic health authority (SHA) of £1.5 million of working capital. In 2004/05 the deficit was £2.158 million (excluding the £1.5 million brokerage owed to the SHA) and a further £300,000 brokerage was obtained. The total brokerage owed to the SHA was to be repaid in annual tranches, starting in 2006/07 (£1 million to be repaid) and completed in 2007/08 (£800,000). In 2005/06 a £498,000 surplus was made,[34] on a turnover of about £113 million, but as will be seen, any satisfaction at this was swiftly dispelled by demands from the primary care trust for contributions to a regional deficit, as well as the prospect of having to repay brokerage. However, a further surplus of £1.126 million was made in 2006/07. Throughout this period there was also a requirement to undertake an annual cost improvement programme.

66. Just before the beginning of the 2006/7 financial year, the primary care trust announced that in order to meet a regional shortfall it would in effect be reducing the amount paid to the Trust by between 2% and 3%. As Mr Yeates was recorded as saying in the HMB minutes of 13 March 2006:

This was a very serious situation for the Trust to be in with the financial year coming to an end...

67. This and the upcoming obligation to repay brokerage and other items resulted in an assessment that from 1 April there would be a deficit of £10 million. In fact, the Trust succeeded in producing a surplus for the year 2006/07 and felt able in the application for foundation trust status of April 2007 to state the following:

The Trust has demonstrated a capacity for performance monitoring, controlling in year cost pressures and delivering challenging Cash Release Efficiency Savings (CRES)... The Trust has a track record of recognising underlying financial issues and taking appropriate action both recurrently and non-recurrently to address them.

[34] The volatility of the Trust's finances is shown by that fact that the Trust Board was told on 12 January 2006 that the eight-month period to the end of November 2005 showed a £1,338,352 deficit

68. A surplus of £1.25 million was planned for 2007/08, and a surplus of £883,354 was achieved.

69. According to the formal accounts, the first year as a foundation trust (2008/09) produced a surplus of £1.678 million, the underlying surplus being £759,000, or around 0.5%, of a turnover of £144 million.

70. The continual pressure to save money, not only in order to break even but also to repay brokerage, contribute to regional shortfalls and meet other targets, resulted in a number of measures being taken every year. These included the following:

- In June 2004 a vacancy scrutiny panel was introduced. This is a means of monitoring all staff vacancies to see whether recruitment to them can be deferred. The process itself inevitably results in delays in replacing outgoing staff. It is meant to save budgeted costs, but can increase the cost of bank, agency and locum replacements.
- In January 2005 a workforce reduction proposal was made to address the recurring deficit by removing 180 staff posts. This was designed to save £5.4 million in addition to a cost improvement programme of £4.6 million. However, at that time nothing appeared to happen as a result of this proposal.
- In March 2006 a staff reduction programme involving 170 posts was proposed.

71. It is by no means clear that the only way in which the Trust could have addressed its deficits was through such staff cuts. The current Director of Finance, Mr Gill, took up the post in July 2008, but had previously worked for Monitor, thereby gaining considerable knowledge of the financial practices of different Trusts. His initial impression on taking up post was one of surprise at how traditional the Trust's approach to financial matters was:

I was surprised for me how traditional the approach was and certainly reminded me of the organisations that I was in back in the 1990s, late 1990s, early 2000 really. Obviously the work – obviously worked with a number of FTs, worked with a number of boards and see a number of organisations that were quite forward thinking in terms of how they were moving the whole finance agenda forward, how they were bringing in devolution, service line reporting and getting clinical engagement into the financial arena... [I] *was surprised at the lack of forward movement in that clinical engagement side of it really which is where I focused a lot of my early efforts really...*

I found a very centralist approach to finance in the organisation basically...

Q: *Does that tend to suggest that the department or the divisions (a) weren't particularly interested in the financial situation or financial affairs and (b) in any event had no influence upon them?*

A: *I think (b) comes before (a) in reality in terms of motivation. The finance director was – he brought the proverbial rabbit out of the hat every March and hey presto he delivered a financial performance. I think that disenfranchises and disempowers the operational people. Whether they were interested or not to a degree follows answer (b) really because if they were interested they would not have been able to get involved hugely and therefore become disinterested and disempowered.*

72. Mr Gill was asked whether, faced with the financial position that faced the Trust in March 2006, he would have acted in the same way:

Would I have done the same in terms of staffing? That is a very difficult one to answer. It is fair to say that if 65 to 70 per cent of your cost basis is staffing it would be incredibly difficult to remove anything like GBP10 million without [reducing] *staff levels. I think the key thing is wherever you affect the staffing levels that you are gaining the assurance about the quality of the service et cetera. You are not just taking the money out and without regard to the consequences. It is about having that regard.*

As finance director it would be completely wrong of me to say 10 million is coming out and I don't care where it is coming from. That would be completely wrong and churlish. But equally as a board member I have responsibilities and accountabilities as well that extend beyond the mere financial and professional portfolio that I have. In terms of patient safety, patient quality et cetera, that is every board member's and every member of staff's responsibility.

73. Mr Gill described the current system that is in place to identify and pursue savings. Without repeating in detail what he told me, it is apparent that he is engaging with departments throughout the year to enable and empower them to put forward savings and efficiencies, rather than imposing them in a top-down fashion. While staff cuts will sometimes be inevitable, under his regime they would not happen without the relevant departments endorsing if not proposing what was proposed. Importantly, he could not envisage presenting a paper advocating such cuts to the Board without what he described as *"clinical ownership and clinical buy-in"*:

I can't imagine an instance where I would say this is how we are going to save it and not have those conversations and discussions because the papers would get blown out of the water.

74. The implementation and effects of the staff reductions which resulted from financial pressures will be considered below. There is, however, no doubt that the Trust Board and senior management placed a very high priority on financial issues. Significantly, until recently financial reporting took priority on the Board agenda, always being considered as an early item. The comment has been made that this could leave little time to discuss other issues. It might be thought that this was a tempting methodology for non-executive directors, many of whose experiences would be in the business world – giving them a familiarity with financial matters that they may have lacked in clinical matters. The Board did not receive much, if any, clinical advice about the effects on patients of what was being proposed. There was certainly no *"clinical buy-in"*. The stewardship of public money is of course vital in the NHS, as it is with any other public service. However, it must be remembered and reinforced with staff that balancing the books is a means to providing a good service to the patients of the NHS and value to the public purse, and not an end in itself.

75. It was submitted by Cure the NHS, citing criticism made by the Trust's external auditors in 2003 and 2005, that the financial governance of the Trust had been weak. While it is true that such criticisms were made, and that the Trust did experience concerning deficits, long-term planning was at the mercy of short-term crises generated by external agencies. A situation where savings in the order of millions are being demanded of a Trust, just weeks before the beginning of a financial year, makes rational planning very difficult. Constant demands for cost savings on a formulaic basis, likewise. Such an environment encourages a culture in which finance is regarded as the top priority, and balance sheets are protected by ingenious action to move money from one pot to another on an ad hoc basis.

Comments

76. If one lesson is to be learned from the Stafford experience, it is that changes made or demanded in haste can be inimical to good patient care. This is not to exempt the NHS from the prioritisation and re-allocation of resources that any government must consider. However, safe and consistent care cannot be delivered unless change is properly planned and risk assessed, with proper engagement of the staff whose duty it is to deliver that care. Finance, in the sense of the resource made available to the Trust, must always be the servant of the Trust's purpose – the delivery of good and safe care – and not the master which dictates the standard of delivery, however poor.

CHAPTER 3
Implementation of staff cuts

77. During the course of the period under review, there were cuts in staff and changes to skills ratios from which the hospital has still not recovered. The change to the skills mix took place in association with the clinical floors project considered above. Whatever may be said to have been the driving force behind them, there can be no doubt that the staff cuts were motivated by a perceived need to save money.

78. A surprising feature of this Inquiry has been the difficulty in establishing the numbers for the funded staff establishment and the numbers in post at any one time. This was a difficulty shared by both former and present Directors of Human Resources and others. Ms Norma Sadler, the former Director of Human Resoucres thought that it had been impossible in her time to work out what the funded establishment was at any time:

The way it works in other organisations is a department will have a funded establishment of 60. If they want to change their funded establishment then there is a process they have to go through: let's say they want to get rid of a post, so they will fill in a form saying they want to get rid of this post. They might want to replace it with a different grade of post so that changes the funded establishment. It will either go up or down. When you have a process like that in place where you can work through what the managers are doing, that's fine. But in Stafford there was no process in place to actually record that. It was done sort of almost on the back of a fag packet with managers. They would mess around with their establishment and then – memories would fail, things would move on and they would forget what they had done. In other organisations where I had worked where I had had an establishment control system which always came through personnel... It was all tied through nicely through the finance department and HR and everybody knew what was happening. That never happened in Stafford.

79. Ms Brisby agreed:

this is going back to 2005... I think that the difficulty was that we didn't really know how many staff we had got. We didn't really know what they were doing, we didn't really know where they were and we didn't know what numbers were reasonable.

Q: *That does sound like a bit of a mess.*

A: *Does it? Sure.*

80. The current Director of Human Resources, Ms Lloyd-Jennings, still found the figures unreliable when she arrived in September 2009:

A: *I was under the impression, we all were when we came in, that we had shedloads of nurses coming in, we were fully established, maybe a couple of vacancies and that is what our financial information was showing us. When we actually look at it, we didn't have those staff actually in post. There were being paid but they were people on temporary contracts, I mean they were bank staff... It wasn't until we started to unpick things that we realised, looking at the two lots of figures, that we actually had much bigger gaps in our substantive staff... I do not [think] people had that information at the time to understand the true picture.*

Q: *Not only didn't they have it, it sounds from what you say as if they would have understood the position to be that the establishment figures were met?*

A: *Yes.*

Q: *Which rather calls into question, or might call into question, the reliability of figures in years gone by as to (a) what the funded establishment was, (b) how many people were in fact in post and (c) what the vacancies were?*

A: *Very possibly, yes.*

81. Mr Newsham was surprised when he heard of these complaints. In his view the finance department had kept accurate figures based on the payroll, and he felt that these were available to others, including the human resources department, to use. However, he did accept that others may have found it difficult to use what the finance department found easy. For example he described difficulties that Dr Moss, former Director of Nursing, had in compiling figures for the staff skill mix review, whereby Dr Moss was told one thing by the human resources department, another by the divisions and yet another in the financial management reports. He thought that the problem was that the divisions were not understanding or acting upon the management reports.

Commission for Healthcare Improvement report

82. It is clear that the Trust had been suffering problems of under-staffing before 2005. In 2002 the then Commission of Healthcare Improvement (CHI), in a report on the Trust, stated the following:[35]

Staffing levels are a cause of concern, particularly in nursing. There are also senior medical posts vacant. The number of nursing staff employed is low compared to other hospitals. The appointment of some of the trust's most senior nurses to work for NHS Direct on the hospital site is perceived by staff to have left the hospital short of nurses at this level.

[35] Commission for Healthcare Improvement (January 2002) *Mid Staffordshire General Hospitals NHS Trust*

83. The report also recorded the following:[36]

The trust recognises that benchmarking against other organisations indicates that the number of qualified nursing staff employed as at the lower end of the spectrum. The trust reported that staff shortages were primarily due to having to follow a financial recovery programme and meet cost improvement targets. Throughout the review CHI received reports of nursing staff shortfalls, which were perceived to directly influence the ability to provide quality care...

84. The CHI supported:

the urgent undertaking of a comprehensive skill mix review which the trust planned to begin in September 2001.

85. In 2002 the Trust formulated a strategic response to the CHI report. In the version of May 2002, the implementation of the above recommendation is said to have been completed. Mrs Harry told me that in many ways this report had told the Trust what it already knew. She had led a skill mix review, and it had not been a question of increasing staffing levels but of:

making sure we got the right staff in the right places.

86. There was an effort to recruit nurses from overseas.

Vacancy scrutiny panel, 2002–04

87. Mrs Harry told me that there had been a vacancy scrutiny panel in 2002/03, and the panel was re-established in June 2004. All requests to advertise posts had to be submitted to it. The procedure for the panel explicitly stated that delaying recruitment should not expose the Trust to increased clinical or other key risks. An elaborate system was put in place to examine the merits of each post, and the aim was to generate non-recurring savings of between £100,000 and £130,000 a month over and above the existing vacancy factor target. It seems clear from the documented procedure that claims of increased clinical or other risk were to be treated with scepticism:

It would be fair to say that in most cases supporting statements highlight the key risk as breakdown or non-delivery of service, inability to meet waiting times etc these comments are generally not supported with more detail, back up or projections... There is little evidence to suggest that as vacancies arise service change opportunities are seriously considered.

[36] Ibid. page 23, paragraph 5.39

88. Mrs Harry assured the Inquiry that the panel did not hold up nursing appointments, but it seems likely that the very process would have achieved what was described as the *"key role"* of the panel, namely *"to slow down the recruitment/replacement process so as to maximise non-recurring vacancy savings"*.

89. As this period was outside the time period under review by the Inquiry I did not seek to examine in detail what occurred, but it seems that the Trust was under-staffed in 2001 and faced constant financial challenges after that, resulting in at the very least a reluctance to recruit. It is therefore difficult to believe that the situation reported by the CHI in 2002 had materially changed by 2005.

Workforce reduction proposal, January 2005

90. At the time the workforce reduction proposal was announced it is recorded that there were 250 vacancies, some of which had been vacant since April 2004. The Royal College of Nursing (RCN) full-time officer present at a joint negotiating and consultative committee on 20 January 2006, where these plans were announced that the was concerned at the number of staff contacting the RCN in relation to staffing levels and work pressure.

91. The Chief Executive considered that there was an urgent need to progress the work force reduction. Indeed, he sought to persuade the staff side at the committee that it should not insist on a 90-day consultation period, which was in fact a statutory right based upon the number of posts that were proposed to be lost. Without any basis in law he suggested that if this consultation period were insisted upon, a further 50 jobs would have to be lost. I have seen no basis on which such a figure could have been put forward, and when the unions failed to cave in to this threat no more was heard of it.

92. A proposal was put forward to the HMB on 24 April 2006 to reduce the overall workforce by 166.81 whole-time equivalents (WTEs), 52 of which would be in nursing. On 30 May the Chief Executive presented a position paper to the HMB which showed where it was proposed that the cuts would occur. Of the 52 nursing posts, the cuts were allocated as follows:

Clinical standards	6
Human resources	1
Medicine	15
Patient access	6
Surgery	24

93. The proposal included a 'summary of risk assessment and risk assessment strategies'. It stated that each divison and department had been required to develop a risk assessment, and that the assessment:

confirms the level of risk and mitigating actions that need to be considered to minimise the impact on the organisation.

94. The summary risk assessment is a remarkable document. It contains no reference as a risk fact to the reduction of nursing staff in medicine. It merely states that the medical division recognised the need for flexible cover arrangements and noted that training requirements to "*skill up*" staff and to "*result in different ways of delivering quality of care to the patients*" were being "*assessed*". The larger reduction in staff in the surgical division is addressed even more blandly:

The changes in workforce skill-mix and the requirement for training and changes in working practices is recognised. Some of the changes were already in progress as part of the Clinical Floors Programme. Many of the changes have been assessed as having low impact.

95. Risks were scored, but only the highest level of score was actually entered. No consideration was apparently given to the difficulties, described above, in working out what the existing establishment was. It is one thing for the finance department to believe it had a grasp of the correct figure, but quite another for the departments to be basing their risk assessments upon data in which they lacked confidence.

96. The proposal was tabled and noted at the HMB on 30 May 2006, but the minutes do not suggest that there was any discussion of the number of risk assessments contained within it. The tone of the minute is that this was all a *fait accompli*.

97. The Trust Board considered the workforce reduction proposal again in private on 4 May 2006, when Mr Yeates reported on progress and the outcome of the joint negotiating and consultative committee meeting. The minute contains no reference to the position paper or to any risk assessment. It does not appear that there was any challenge from any Board member to the proposal or to the way it was proposed to implement it. No reference was made to this proposal at the open meeting on the same day.

98. The conflicting evidence before the Inquiry with regard to the executive responsibility for the skill mix review has been referred to above. This conflict also applied to the responsibility for supplying input into the impact on nursing services of the workforce reduction. As pointed out by Counsel to the Inquiry, it did not prove to be possible to find anyone who accepted that responsibility. The Director of Clinical Standards and sometime Chief Nurse was certainly present at the HMB meeting on 24 April 2006 when both the skill mix changes and the workforce reduction were discussed. However, she told the Inquiry that she was not involved in the identification of the posts to be reduced. Her explanation was as follows:

I was present at the meetings but the work that was done to identify the figures and the figures that were presented to medicine was done within the directorates. And that is what was asked for, that the directorates go away and come back. The directorates manage their own budgets and therefore the responsibility for them delivering the financial targets sat within the directorates.

99. She was unaware whether any risk assessments had been carried out. What seems clear, therefore, is that there was no nursing voice putting forward nursing-based concerns, either at the HMB or the Trust Board, on a proposal to reduce the nursing staff by 52 WTEs, or advising on the potential impact on services in the affected areas. Furthermore, there is no evidence that directors asked for any such advice.

100. The importance of this gap in professional advice and consideration is demonstrated by what happened in the following year. The Trust has been unable to provide the Inquiry with figures of how many nursing posts were in fact lost as a result of this programme. It is likely that a significant number of posts were lost. By the time of Helen Moss's arrival as Director of Nursing in December 2006 it was appreciated that there were significant staff shortages. While the resulting review only reported in March 2008, it disclosed that the Trust needed to increase its nursing establishment by 120.39 WTEs, of which 76.78 were in the medical division and 30.28 were in the surgical division (the remainder were in the clinical support services and corporate divisions). In addition a need for nine matrons was identified. Counsel to the Inquiry makes the not unreasonable assumption that this means that, had Dr Moss's view been available and prevailed in 2006, instead of a reduction of 52 WTEs among nurses, an increase of 77 WTEs would have been shown to be necessary. Even if the matrons are regarded as having been proposed as an enhancement, a shortfall of 68 would have been identified. This assumes that all 52 WTEs were in fact lost in the intervening period. If they were not, the original shortfall would have been even greater. No change in the hospital's service in the intervening period, which might explain this discrepancy, has been pointed out to me. Therefore I conclude that a reasonable nursing opinion obtained in April 2006 would probably have indicated that there was a nursing staff shortage and that there was no scope for cuts in that area.

101. It is perhaps appropriate to end this section with a comment made by Dr Moss:

If it was me and I was being asked to do a workforce reduction or changes, I would want to have a thorough piece of work behind it.

102. I can find no evidence of any thorough or effective review of this type preceding the implementation of the reductions.

Workforce review, 2007/08

103. Dr Moss arrived at the Trust in December 2006. Shortly after she began, staff shortages were highlighted to her as an issue. She decided that the Trust needed an independent review, as she could find no one internally with the expertise to undertake it. She had difficulty in finding a suitable person to do this. She pointed out that this sort of exercise is complex and is not just a question of numbers. There are tried and tested models for conducting establishment reviews.

104. Like others before her, Dr Moss had encountered difficulty in finding out what the establishment numbers were. She did not regard the information available from the finance department as particularly helpful, and found that those responsible for recruiting did not have confidence in it.

105. It is difficult to understand why the review took until March 2008 to complete. Dr moss pointed to the difficulty in finding someone to undertake the review and the complexity in reviewing over 60 areas of activity. She had appreciated that there was likely to be a significant cost attached to the finding of additional staff, and wanted to present a robust case. There was also the need to engage the staff, both front line and finance, in the project, which was using methods with which they were unfamiliar. While it can be accepted that all these issues played a part in the duration of the review, it does not justify the time taken. It was apparent to the incoming Director of Nursing that there was a serious issue with regard to the skill mix and staff numbers, since staffing clearly impinges on the standard of care provided to patients – and even their safety. Therefore it should have been accorded the highest priority and dealt with urgently. Questions from the Inquiry's nursing adviser established that the only resource allocated to the review was the external adviser, and no management structure was put in place to support it. Without the information provided by this review, the Trust Board did not have adequate information to judge what needed to be done to fulfil its duty to the Trust's patients.

106. When the Board received the review at its meeting on 31 March 2008, there was discussion about what its conclusions meant for the decision to reduce the workforce in the first place:

The investment required to meet the shortfall identified from the Trust's reserves was 1.15 million and a further 550,000 funding for Littleton ward would come from the PCT...

It was believed there would be some improvement in the sickness levels once there was an establishment improvement.

It was asked whether the Trust should be reflecting on its cost improvement programmes in the light of the present situation. Had it been right to take nurses out of the establishment at the time they had been? The Trust board were reminded that the board had taken the decision to take out GBP10 million of expenditure. The alternative [would have] *been a downward financial spiral. It was not believed that the 10 million taken out had had a large impact on the nursing establishment, which was an historic issue. When the workforce reduction was decided upon, it had not been foreseen that there would also be a sickness absence problem. Difficulties had arisen due to the combination of turnover of staff, sickness and difficulty in recruiting.*

107. This defensive conclusion does not recognise why the review had shown a need for so many more nurses. The funded establishment figure will take into account an average absence through sickness and other causes; if there is an appreciable excess over that figure of absence, then other causes need to be looked for. It is well known that sickness rates increase when staff are stressed or demoralised. It seems a more likely explanation that sickness was caused by the stresses of under-staffing. In any event, sickness cannot explain why this review determined that a higher establishment was required than existed before the workforce reduction.

108. The Board did not react to the review with great urgency. The funding figure mentioned above was insufficient to resolve the whole staff deficit: it funded only around 38.4 of the 120 WTEs needed. It was envisaged that this would be a first tranche followed by others. Even so, attempts to increase the staff have met with limited success. By November 2008 the Board minutes were suggesting that the numbers recruited were still 40 below the establishment recommended by the review. Even now the nursing establishment is short of the figure envisaged by the last review. Although the Trust had increased its funded nursing establishment by around 79 WTEs, at the time of the hearing they had only succeeded in filling 10 of those posts; however, 41 more staff were waiting to start – subject to vetting.

Comments

109. Something must have gone seriously wrong for the Board to have permitted a substantial nursing workforce reduction at a time when the hospital was already under-staffed without an effective risk assessment, reliable establishment figures or a skills review of the type later instituted by Dr Moss. The emphasis in Board discussions was almost entirely on the financial advantages of the move. The effect of the reduction was to make the situation on the wards even more difficult to manage than had been the case before; to exacerbate the effect of the clinical floors programme (the effect of which does not seem to have been reviewed at the same time); and to contribute to the substandard care being provided. For Dr Moss to set up the review as one of her first acts shows that it must have been obvious to her that there were staff deficiencies. It seems to have taken far too long to complete the review, and even after it was produced showing the size of the deficit there has been insufficient urgency in remedying the unacceptable staff numbers. One of the results was that the HCC was able to find highly concerning substandard service provision, as reflected in its letter of July 2008. It is impossible to avoid the conclusion that the Board neither received nor sought sufficient professional advice about the impact of the changes it was approving in terms of the workforce reduction, and then when it was told that there were or could be staff deficiencies, failed to follow up those concerns with any urgency. It has been suggested that one cause of that was the focus on obtaining foundation trust status, and it is difficult to disagree. However, another reason is to be found in the absence of effective clinical governance – a matter considered in the next section.

PATIENT STORY

I heard from the son and daughter-in-law of a 90-year-old woman who lived on her own and was an extremely active and independent woman. They described her as a keen gardener who, despite her diabetes, led a *"completely normal life"*. They told me that the whole family loved her very much.

Her son told me that in October 2008 his mother had a fall and was taken by paramedics to Stafford Hospital. After nearly six hours of waiting in A&E, she was found a bed in the emergency assessment unit. Despite the wait, she was quite cheerful and was able to sit up in bed. She was treated for high potassium levels and placed on a saline drip.

That evening his mother was examined by a doctor and was asked a couple of questions to test her memory. She was able to answer one question but not the other, which the doctor said was quite normal. She said that she was hungry so her son helped her open a sandwich, which had been placed out of reach. He recalled that there was nothing for her to drink with the sandwich. When he left that night, despite her fall, he remembered that she looked bright and well.

The following day both he and his sister visited their mother and noticed that she seemed unable to use her arms. He tried to find a member of nursing staff to discuss this with, but could not find anyone who could help.

His mother's condition deteriorated further and the next day she became extremely confused, telling her son that she thought she was dead. His wife noticed that his mother was not wearing her own nightdress and found it in the bedside cabinet. She also noticed that there was a huge amount of gauze on the back of her head, and a bandage. After demanding an explantation, the ward sister informed the family that their mother had fallen during the night. The patient's son was so concerned that he insisted on seeing a doctor, but was told that one was not available. Once he and his wife arrived home, they took his mother's nightdress out of the bag to wash it and were shocked to find it *"saturated in blood"*.

The following day he spoke to a doctor; however, the doctor had been transferred from Stoke Hospital that day and had no knowledge of his mother's case beyond what was recorded in her medical notes. His mother was then transferred to Ward 10 where she was due to go for a computerised tomography (CT) scan.

Her condition continued to get worse and the patient's son received a call to tell him the CT scan had revealed only mild shrinkage of the brain, which was described as normal in a person of his mother's age. No further concerns were reported.

Later that night the patient's son received another call to tell him his mother had suffered a further fall, and he was asked to come to the hospital. When he arrived, he was told he could not see his mother immediately and was taken to a side room. His sister arrived unnoticed and went straight to their mother. She came in tears to fetch him and he recounted what he saw: *"My mother was lying... full stretch out on the grey marley tiled floor. Some effort had been made to remove all the blood. It was smeared all over the floor. You could not see a hair on her head. It was completely swathed in bandages. And there was a lady doctor holding my mother's head in her hands."*

The doctor told him that his mother had not been in bed at the time of the fall, but had been in a chair. He realised that his mother may have been left to sit in the chair from when he had seen her at 3.30pm to when the fall occurred at 10.30pm. He recalled saying, *"Oh mum, what have they done to you... This is my mother,"* to which the doctor replied coldly *"I have got a mother too."* The son remarked to me, *"There was no compassion in that woman whatsoever."*

His mother was subsequently sent for a further scan. The doctors said that she had a huge bleed on one side of her brain and a smaller one on the other side, and that her brain was also swollen. They told the family it was impossible to operate, and that if she regained consciousness then she would not be the same.

The patient's son then learned that his mother had suffered a further previous fall that he had not been made aware of, and a doctor said to him, *"We have let you down."*

The following day the ward sister was very anxious to explain to the family what had happened to their mother. She told them that their mother had experienced *"two insignificant falls"*. The patient's grandson challenged this, suggesting that the falls were significant as they were indicators that his grandmother was vulnerable and at risk of further falls. The patient's son went on to ask the ward sister what her reaction was to his mother's third fall and she said, *"Do you want to know what I said after the third fall... oh bloody shit."* He found her attitude extremely distressing. To the devastation of his family, his mother sadly passed away a short time later.

He told me that following his mother's death, he complained to the Patient Advice and Liaison Services (PALS), who he said were quite supportive. He had two meetings with the hospital and received an apology and a copy of an action plan. He did not think this was good enough as he was left feeling that nothing positive was going to result from this tragedy.

This lady's son remarked to me: *"Believe me, Stafford Hospital did let us down. They let my mother down, they let her die and they let us down as a family with the information they failed to give us. I will never forgive them for that."*

Section E
Governance

Introduction

1. There has been an increasing focus on the importance of governance in the NHS since the Bristol Royal Infirmary Inquiry (July 2001). The methods by which governance is delivered can be very complex, but its purpose is simple: to ensure through a system of information and accountability that a proper standard of safety and care is provided to all patients. Clinical governance has been defined as:

   A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.[37]

2. The concept of governance as it is now understood cannot be described as new or as an esoteric matter known only to a few. Developments that took place towards the end of the 1990s resulted in the publication in June 2001 of *A Commitment to Quality, a Quest for Excellence: A statement on behalf of the Government, the medical profession and the NHS,*[38] which was endorsed not only by the Government and the Chief Medical Officer, but also by the Royal Colleges and the General Medical Council (GMC). All parties committed themselves to implement a number of elements, including:[39]

   - health organisations continuously assure and improve the quality of their services;
   - the quality programme enhances the achievement of the goals of major clinical programmes;
   - teams of health professionals together practise safely, to a consistently high standard, and develop and improve, in both primary and secondary care;
   - risks and hazards to patients are reduced to as low a level as currently possible; and
   - emerging problems are identified at an early stage and appropriate action is taken.

[37] G Scally and L J Donaldson (1998) *Looking Forward: Clinical governance and the drive for quality improvement in the new NHS in England*

[38] DH (June 2001) *A Commitment to Quality, a Quest for Excellence: A statement on behalf of the Government, the medical profession and the NHS*. Professor Hutton, one of the Inquiry's specialist advisers, was a co-signatory of this statement in his then capacity as Vice Chairman of the Academy of Medical Royal Colleges

[39] Ibid p. 6

3. The following year the Department of Health (DH)[40] issued an operational guide informing NHS Trusts that they had responsibility for, among other things:[41]

   - ensuring that clinical governance principles, processes and systems are embedded through the Trust Board and within the organisation;
   - ensuring that services commissioned from, hosted by or jointly provided with other providers comply with the statutory duty of quality and principles of clinical governance and patient safety;
   - ensuring that, at a local level, systems and processes are in place to ensure the delivery of safe, high-quality care;
   - ensuring that all clinicians are involved in the regular clinical audit and review of clinical services;
   - assessing performance and identifying training needs for all staff;
   - developing an open culture within the organisation whereby incidents are reported and lessons are learned;
   - ensuring effective risk-management processes and accounting for clinical governance responsibilities when signing their statements of internal control; and
   - monitoring trends in key clinical quality and outcome measures.

4. A reporting framework addressing these issues was formulated and had to be in place by 2002/03.

5. The same guidance outlined the various areas that NHS Trusts should draw on in their reports:

   - patient experience, including planning/organisation of care;
   - use of information, including patient experience, resources and outcome of care;
   - processes for quality improvement, including risk management, audit and learning from incident reports and complaints;
   - staff focus, including staff management, continuing personal development and multi-disciplinary team working;
   - leadership, including patient involvement, clinical leadership, service planning and organisational performance review.

6. Whatever is done by way of governance it is important that information derived about how the Trust and its staff are performing is obtained by the Trust Board so that it can assure itself that proper standards are being observed and inform itself of the need to take corrective action.

[40] DH (November 2002) *Clinical Governance Reporting Processes*
[41] Ibid, p. 2

7. As Ms Brisby, former Chair of the Trust, put it in her evidence, there needed to be:

... a process which feeds reliable information up to the Board, so that the Board essentially has to work with the high level information and an overview. It is never going to operate with detail, but there needs to be a process which makes sure the detail doesn't get lost on the way.

8. In her statement, she was emphatic as to its importance:

... effective governance is the key to providing the best service and ensuring patient safety, and that without good governance it is quite impossible for a Board to be effective.

9. Many non-executive directors will be more familiar with financial governance from their business activities, and less familiar with clinical governance, where the significance of information may require expert professional assistance. It was a feature of the Trust, acknowledged by present management, that the Board focused on financial matters at the expense of the clinical. There is no doubt that this led to a lack of awareness of the gravity of the deterioration in the standard of service, for which the Board was responsible for delivering.

Initial lack of arrangements

10. A constant theme at the Trust has been a perception that it has not had effective clinical governance. This was known for a protracted period by a wide variety of people in senior positions:

11. In their report of the Clinical Governance Review of the Trust conducted in 2001, the Commission for Health Improvement (CHI) found there to be a lack of effective clinical governance.[42]

12. Ms Brisby had previous experience of governance procedures in her role as a non-executive director at another NHS Trust, including being a complaints convenor. On her arrival as Chair in 2004, she was unaware of the CHI findings, but what she saw was very similar:

... there was no effective governance. There was a very poor flow of information. It was very poor information anyway, there was muddled data collection, there were a very complicated incomprehensible structures of committees and it was very unclear which committee reported to which or what the functions were. There were few terms of reference. I mean I could go on.

[42] Commission for Health Improvement (2002) *Report of a clinical governance review at Mid Staffordshire General Hospitals NHS Trust*

13. The Medical Director between 2003 and March 2006, Dr Gibson, stated in written evidence to the Inquiry that he couldn't comment on the lack of effective governance arrangements because:

I had no responsibility for clinical governance in my role as Medical Director.

14. In 2006, a clinician appointed as lead on clinical governance found no evidence of:

Any functioning structure for managing clinical governance... [By functioning I mean that] *we had some basic principles that we were following them, and that we were getting outputs as a consequence of them, hopefully benefit to patients, changes in staffing attitude or policies or practices. There seemed to be a black hole as far as that was concerned from my perspective.*

15. In the same year, Dr Suarez became Medical Director:

When I came into post... there was no governance structure. There were a lot of things that weren't happening. I think you can go back over time and see that it was a long time that we weren't getting into control of what we were delivering.

16. The former Chair of the consultant staff committee could not recall, looking back, there being routine reports on the standard or quality of care at the Board while he was an observer there:

I can't recall it, no. Well, there was – there was a governance section, and if one thinks back, I mean, before that year, I mean, really before Martin Yeates was appointed, there was no systematic system of governance. It was very, very haphazard and there wasn't a risk register and the risk register was a very sort of bureaucratic instrument, but – and the assurance framework that was sort of linked to it, but there wasn't anything before that. So that – I think that in terms of governance arrangements, the Trust was starting from a very, very low point.

17. The Head of Governance, formerly Deputy Director, said there were no governance arrangements when she arrived in February 2006. According to her, they only started to be implemented towards the end of 2006 and the beginning of 2007.

18. The Director of Clinical Standards until she left in July 2006, Mrs Harry, was asked why there appeared to have been no effective governance during her period of office. She did not accept this asserting that systems had been put in place, which she described. It is not possible in this report to analyse her answers on this subject in detail, but I was left with the distinct impression that this witness equated a committee structure and policies with an effective system. It is quite clear from the other evidence cited above that there was a widespread staff view that whatever structure and policy there might have been, it was ineffective.

Ms Brisby argued that the concept of clinical governance had been in its infancy starting with the Bristol Inquiry. While this may be open to doubt, in that even before Bristol many specialties had their own systems of audit and review, and complaints and incident reporting also existed, it is difficult to understand how Stafford could remain as far behind the accepted practices of other Trusts, which, my advisers tell me, they consider it was. As will be seen, effective clinical governance was largely absent in many areas, even if a theoretical structure for its provision was in place.

Clinical governance arrangements from August 2006

19. As has been seen, Ms Brisby not only appreciated the importance of good governance arrangements, she realised that they were absent from the Trust when she began in 2005, and appreciated the need to change this. Part of the solution, as far as she was concerned, was to apply for foundation trust status and to use the requirements of that process as a driver for improvements in clinical governance. In her statement to the Inquiry, she explained that:

    *As a Board we took the decision to go through the Foundation Trust application process as a way of making sure that the changes we proposed to make would be in line with what was commonly seen as best practice and subject to proper external scrutiny. Our clear objective was to ensure that we were providing the best possible service to patients and their families.... **All of the actions that the Board decided needed to be taken concerned good governance, and this was the main reason for pursuing Foundation Trust status**, as the best means to the desired end of delivering a continuously improving service to patients* [emphasis supplied].

20. In her oral evidence, she explained that she did not see the relative financial freedom available to foundation trusts as the principal attraction of the status, but that:

    ... having a whole series of outsiders come in and go through our governance arrangements and give us feedback seemed to me to be a really, really valuable exercise. It was painful and difficult but it was very valuable.

21. It is unhelpful to consider in detail the committee structure set up around governance before August 2006, but significant changes were made in and from August 2006. A governance and risk strategy was published in September 2006, and as a result a Clinical Governance Group was set up, holding its first meeting on 3 November 2006, chaired by the Trust Lead for Clinical Governance. It was to report to the Trust Executive Governance Group quarterly.

22. Dr Moss, Director of Nursing and Governance, arrived at the Trust in December 2006, and at her first meeting of the Governance Executive Group expressed concerns about the structure, supported by the Clinical Lead and the Medical Director, Dr Suarez. Dr Moss told me about the arrangements in place on her arrival: there were meetings taking place, but the information being received was *"weak"*. The steps that she took to remedy this included the appointment of the former Deputy Director of Clinical Standards as Head of Governance in April 2007, and the promulgation of a Governance Strategy in September 2007. This was a comprehensive document recognising the statutory obligations of the Trust and defining roles and responsibilities for governance.

23. The Strategy also defined the reporting structure and the terms of reference of each committee or group in the structure. This was set out in the diagrammatic form attached in Appendix 7. Of note is that the Executive Governance Group reported to the Audit Committee and not directly to the Board, and was the filter for all information coming from complaints, risk assessments and clinical groups. The divisional governance groups were three steps from the Board and the clinical groups four steps. The two clinically trained Executive Directors, the Medical Director and the Director of Nursing and Governance were the only routes through which clinical or nursing concerns were likely to reach the Board. The Head of Governance told the Inquiry that the systems outlined in the Strategy had in fact been in place since April 2007.

24. An examination of the minutes of the various groups confirmed the concern that the higher level committees were not receiving or addressing governance issues as a priority. The Audit Committee in particular, perhaps understandably, placed emphasis on its financial role, and other governance issues, particularly clinical governance, seemed to appear further down the agenda. Likewise, the Board minutes appear to focus on financial matters. This may be in part due to the style of minute-taking, but even that tends to reflect the focus of interest to some extent. In the absence of minutes, it is more difficult for matters to be followed through at subsequent meetings.

25. This system did not meet with the approval of some senior witnesses. Dr Suarez, the former Medical Director, thought the system was too complex to allow for clear communication to the Board:

    Q: *... was the make-up or the number of committees an additional complexity, a problem to clarity of communication?*

    A: *I would say it probably was. It was quite – the committee structure in the hospital has been subject to a number of changes over the years. You need to make sure you have everything captured but on the other hand, there is a danger that it becomes too complex and certainly from clinical quality and effectiveness*

group, going through two more committees before the Trust board, I do think did inevitably dilute some of the content.

26. The Lead for Clinical Governance, although involved in setting up these procedures, agreed:

I had concerns about the proliferation of committees and the kind of unwieldiness of the whole thing and I had serious doubts about, as we have just discussed, about problems actually progressing up the tree in the way that it was designed to allow, and so despite the fact that I had on a number of occasions said I thought it was too unwieldy, it was basically put in place.

27. His principal complaint was that there was a lack of clarity in the roles of the various groups, further weakening the chain of communication:

Something is better than nothing. It was more effective than what had happened before... I really felt that we had in place now a series of committees which if they functioned as they should have done, would provide us with decent upward and downward flow of information, but..., for example... I never really understood the role of [the Executive Governance Group] *... couldn't really see what the point of it was, and I simply felt that the divisional governance groups should be reporting into the clinical quality and effectiveness group and that in a sense should be a direct conduit to the Trust Board. I just felt there were too many* [groups] *– I felt problems that we might come across would be, if you like, filtered and weakened as they progressed up the chain, as opposed to having some direct access to the chief executive and the Trust Board to deal with problems.*

28. The Head of Governance acknowledged that, although the structures were in place, with hindsight it was possible they were not effective.

29. These critical views offered by some of those who actually participated in the devising of the structure were confirmed in rather more blunt terms by the current Chief Executive, who told me:

The governance system in Mid Staffs, if you looked at the chart that was produced as part of the flow of decision-making, the different committees, it looked as if you had thrown half a dozen spiders on to a piece of paper, having been dipped in ink, it was so confusing.

A lack of focus ... focusing on the wrong things rather than sticking to the knitting... it is a hospital, we care for patients. It is a relatively straightforward job and hospitals exist to care and heal patients and they have no other purpose apart from employing staff, but that is a consequence.

But the organisation's agenda even at the point I arrived was immensely confused and unfocused to the point where [Dr Obhrai] *will remember an executive team meeting that I attended had 25 agenda items on it. Not a single one of them had anything to do with the issues that it faced, so a good example of poor governance.*

30. The current Chair added:

It was actually worse than that when I started. Most successful foundation trusts have moved to this integrated governance model where the audit committee picks up all the clinical assurance issues as well as the organisation-wide financial issues and they moved to a model like that in Stafford, and I attended one meeting of the Audit Committee, and clinical quality issues were barely touched on because of the volume of other issues that the audit committee needed to address.

Upwards communication of concerns

31. The structural obstacles to clear communication of concerns perceived above were not merely theoretical. Witnesses acknowledged that matters were not reported upwards with specificity or with ease.

32. The Lead for Clinical Governance commented that the divisions did not report concerns upwards unless they themselves felt unable to resolve them:

... if something appeared on their report, it was because they had been unable to solve a particular problem. But I think what didn't appear on the report was probably of more significance, in the sense that we assumed that any governance issues that they had, they had solved themselves and if they didn't put something as a concern, then any ongoing issues would have been solved at divisional level.

33. Thus the substance of complaints received was not routinely reported above divisional level. This was confirmed by the Head of Governance:

It was trend analysis rather than detail.

34. An example of even more general concerns not being reported upwards is provided by a discussion that took place in the Clinical Quality and Effectiveness Group on 27 March 2007, about standards of care identified on the second floor. The Group had noted that:

... 40 patients had 3 trained nurses across floor to care for them, this was insufficient.... Discussions had taken place regarding transferring healthcare support workers.

35. The Lead for Clinical Governance, the Medical Director and the Director of Nursing all agreed that this sort of concern should have been escalated to the Executive Governance Group, but it does not appear this happened.

36. The failure of the Board to challenge or to follow up serious concerns is exemplified by its approach to the problems identified by the Healthcare Commission (HCC) in A&E, which have been confirmed by the evidence received by this Inquiry. The Board were aware of the difficulties. The senior medical staffing was described in a Board minute of 5 October 2006 as *"suboptimal"*:

    One consultant was leaving. There had already been a vacancy for some time. Recruiting good quality A&E consultants was difficult. The middle grade posts were difficult to fill and locums were very expensive.

37. The proposed solution was that quiet nights would be covered by junior doctors, busy ones by middle-grade doctors, and that the consultants would have to work long hours. The minute suggested that a risk assessment had been undertaken, but the senior consultant was completely unaware of this. If one had been done, he had not been involved in it. In his view, this state of affairs

    was a disaster, an absolute disaster for patients.

38. On 3 May 2007, following a review of complaints and incident reports from April 2005 to December 2006, the Board concluded that:

    ... there did not appear to be any obvious issues relating to the care and treatment of patients who use the Trust's emergency services.

39. Yet a further review in March 2008 of the first three quarters of 2007 found that complaints had increased. The Board appear to have taken reassurance in observing that there had been a reduction following completion of building work. Yet in May 2008, only two months later, the HCC inspection resulted in the findings of their letter of 23 May. The Board's reaction was a complacent one. The minutes of the meeting on 30 May 2008 record the Board's view that:

    The majority of the issues raised in the letter were already known to the Trust and were being dealt with.

40. It is to be observed that even this letter, requiring urgent action, was only discussed at the meeting, which was in private, after the financial report.

41. I shall now turn to specific areas of governance where serious concerns have been raised.

Audit

42. The HCC report identified the failure of the Trust to comply with recognised standards of clinical audit:[43]

    The trust generally performed poorly on clinical audit. There was no one taking the lead for clinical audit for a year and the trust-wide group did not meet at all during this period. When audits were carried out, there was no robust mechanism to ensure that changes were implemented. When re-audits were required, they were often not undertaken, even if they had been recommended by a Royal College. The trust did not participate in many of the national audits run by the specialist societies.

43. Dr Suarez agreed that, when she became Medical Director, audit arrangements were less than satisfactory:

    Individual clinicians are required to audit their own practice and the majority do. I think there were a lot of people doing a lot of audits, some more effectively than others. What we didn't have for some time was anybody in the clinical audit lead role pulling all this together, asking whether we had re-audited in several areas, whether we had a general purpose and sense of where we were going with clinical audit. There are three clinical audit facilitators whose job is to facilitate audit but not necessarily do [audit], and whether we were using them in the best way for the Trust. None of that was really being addressed. The role was vacant and had been vacant when I took up post. It took me a little while to appoint somebody into the role. It lacked direction. They were all doing their own thing but there was no pulling together and making sure that we had a clear priority of the audits that we were doing.

44. She was only prepared to say that the situation was now improving rather than having improved.

45. Mrs Harry observed that *"When I first went there, clinical audit was out alone"* before being brought into a structure. She thought that the Trust had:

    ... good clinical audit programmes, worked hard to make sure that the projects were focused on the areas that were the core services of the trust, core businesses of the Trust.

[43] Healthcare Commission (March 2009) *Investigation into Mid Staffordshire NHS Foundation Trust*, pp. 8–9

46. While this assertion may well have been true for some areas of the hospital, it was not true across all areas. A colorectal surgeon was asked:

Q: *... do you as a team undertake any form of clinical audit or morbidity reviews?*

A: *We have recently started doing it.*

Q: *How recently?*

A: *Less than six months ago.*

Q: *How does that compare with the practice of colleagues in other places?*

A: *Very badly... I have raised it myself many times over...* [with the medical lead and the Head of the Surgical Division] *and they showed no interest because* [of the time commitment]*... all of us could turn up* [only] *if there is a fixed commitment...* [it was] *felt it was too high a price to pay. I was told by* [the Head of the Surgical Division] *that we had such huge waiting lists and all that and targets to be met and we could not possibly sacrifice clinical sessions in order for this – from my point of view, very clinical business to be conducted.*

47. Dr Gibson, who as discussed earlier said he had no responsibility for clinical governance, also told the Inquiry that the hospital did not routinely have morbidity and mortality (M&M) meetings,[44] and that audit was internal to divisions. Critical incidents were reported to him on an informal basis, but there was no formal documentation and hence no record of an accumulation of particular issues. Hospital-wide audit and mortality was also not systematically reviewed.

48. Even today, clinical audit is not satisfactory in some parts of the Trust. The Lead for Clinical Governance also agreed that the individual participation in audit was poor. The Inquiry heard that even practitioners who did audit their own figures found it difficult to get appropriate support. Another surgeon told me:

I can give you information from my own personal database on mortality, morbidity, complication rate, length of stay, but that is only on my patients. Because I do not maintain the database for follow-up, I can't give you long-term outcome data and for a big speciality like bowel cancer, that is quite a serious failing. I can't tell you what my figures are for five-year survival, for example.

Q: *Can colleagues of yours do that elsewhere?*

A: *Yes, they can, because they have been contributing to nationally agreed databases. But the sort of statistics we can rely on are just what the hospital collects in the ordinary PIMS* [patient information management] *system, which is demographic data, date of admission, date of discharge, that sort of thing.*

[44] Deaths and complications of treatments are reviewed and learnt from at morbidity and mortality meetings

But we don't have any information on the co-morbidity of our patients. We don't know how high risk they are and we don't have long-term information on their outcome.

... I think unfortunately we are working in an information vacuum... [colleagues in other hospitals] *have support to do it... they have more support for data collection. So they can contribute to the databases themselves; they have data managers who go out and seek missing information and bring it all together, and they have full-time data managers bringing this together. That is just in one speciality. But in Stafford, it needs to be done across the Trust for all specialities... there is no hospital-wide system for collecting robust clinical data... this is something I have tried to highlight and try to appeal for more help with, a data manager, relatively inexpensive person to employ, but would be a huge asset just to be able to collect reliable data. Over the years it has always been turned down because it was seen as a low priority.*

49. The recent review by the Royal College of Surgeons of December 2009 into the surgical division, which is discussed in more detail below, identified weaknesses in clinical audit in that division. Also, the current Chief Executive reported to me:

    [It was] *a worry that actually the whole audit process round general surgery was not good enough, and they recommended that the lead clinician for audit was removed and we replaced them.*

Comments

50. Clinical audit as a concept has been a professional requirement for a considerable period of time. The evidence I have received suggests to me that clinical staff at the Trust have abrogated responsibility both with regard to the need for each clinician to audit his or her practice, and the overall contribution this makes to the well-being of the Trust and its patients.

Incident reporting

51. Incident reporting is an important means for the Trust to learn of concerns and deficiencies and to enable these to be corrected. An effective system for incident-report handling must encourage staff to make reports, ensure that they are investigated promptly and effectively, draw the appropriate lessons learned and translate this learning into remedial action. All this requires a well-managed system, which attracts the cooperation and support of staff at all levels. The evidence shows that the Trust has consistently failed to achieve this, at least in the eyes of the staff, including some of those charged with running the system.

52. Initially the system was largely paper based: a form would be completed by a staff member, handed to the line manager, and passed to the directorate office, where it would be logged on to a computer. This system resulted in a time lag between the filling in of the report and it getting into the system; this meant that there was never any up-to-date information about trends.

53. In April 2007, an online reporting system was introduced, but this has not met with a favourable reaction from staff. It is not thought to be user friendly, takes time to use, and therefore discourages reporting.

54. Whichever system was in place, a universal complaint from front-line staff witnesses has been that they receive no feedback about reports they have filed, and in particular they are not informed what is being done about the matter of concern raised. A common description heard in evidence was that the forms seemed to *"go into a black hole"*.

55. One nurse told me:

I think at that time there were questions to what happened with the incident forms and I think that was – people didn't get feedback and the term that [is] *used is they seemed to go into a black hole and it felt like that to some staff.*

56. A former nurse, who had been a whistle-blower, said:

It is a good description of it. The routine was that they would go to your line manager. Obviously, that is what you did. But you never heard anything back … if they were really, really serious I would often approach the line manager, whoever it was at the time and say: I put a copy of whatever on the date of whatever [on] *your desk. I haven't heard anything back. Oh, I have a pile this big to get through, I will get round to it, that sort of thing.*

57. An advanced nurse practitioner said:

Patient care was not up to acceptable standards. I myself – I think I may have mentioned this in the narrative – I filled out incident forms quite liberally to try to bring to someone's attention what was actually happening, to highlight poor care issues. We got the impression that nothing was changing.

58. Another nurse said:

There was this comment that they got filed in the bin, that no matter how many times you filled out an incident form, it made no difference, and people were very negative, very cynical.

59. Many reports attributed incidents to a lack of staff. The HCC found that over the course of a three-and-a-quarter year period, 515 incident forms were filed in respect of Wards 10, 11 and 12, of which 37% referred to understaffing. It was therefore of concern to hear evidence suggesting that staff were discouraged from filing incident report forms where this was an issue.

60. One nurse told me:

... probably 12 months ago, I remember the staff in the surgical area, which was a particular concern to us, were so demoralised, and they were saying they were frequently working short staffed and you would say: have you submitted the incident forms? One of the comments from the matron there was: if you have time to complete an incident form, then you don't need more staff. This was even after everything that happened. So that really wasn't the kind of support that the nursing staff were looking for.

61. Another nurse said:

I think it may well have been at a nurses' forum but what was said is that there's an increasing number of incident reports coming in to say that staffing levels are insufficient and that the care being – it is not safe, that the care isn't safe.

62. The reported managerial response was that nurses should take care in making such statements, because it implied nurses were not acting properly in their jobs, and by implication, if patients were not safe, they were being left at too high a risk. The witness persuasively suggested to me that there was a perception that incident reports of this nature were not welcome. In any event, this witness has said that she told her colleagues to ignore what had been said.

63. The Deputy Director of Clinical Standards accepted that she had been told that, before her time, staff had been told not to file reports about under staffing, although she had not done so herself.

[The staff] *certainly weren't being told not to do that during – that I am aware of, during my time but I do remember somebody referring to it previously... that they had been told not to.*

64. These perceptions are likely to have contributed to the other feature noted by staff: an increasing reluctance to report incidents.

65. The Deputy Director of Clinical Standards said:

I think there was a general apathy, certainly in A&E... that they weren't reporting, they didn't see it as a particular – of particular value and therefore didn't do it.

66. The advanced nurse practitioner concurred:

Q: *The other point you make is that because of that perception some people take the view it is not worth spending the time and trouble sending in the reports in the first place.*

A: *I think that is right. If you have been conscientious enough to do that, you are doing* [so] *for a reason. You want to highlight it and get feedback that changes things. If you are not getting that it is futile....I have no hard and fast evidence of that, but it is my suspicion that there is an under-reporting of incidents.*

67. The Trust seems to have done very little with the reports it did receive until recently. For example, I was told that the increase in reports of understaffing on Wards 10. 11 and 12 up to August 2008 referred to above, and detected by the HCC, was not previously known to the Trust because:

...we didn't start to do our trend analysis until 2007. We had started to do a little bit of touching on it with these what we call variance reports, but actually it was 2007 that we really started to look into what the concerns were.

Comments

68. It is clear that although, in theory, the Trust had an appropriate incident reporting system, in practice, it was ineffective. Staff had no confidence in it, they were even discouraged from using it, there was no feedback to staff, and there is evidence that the reports were not used to identify areas of systemic concern. Not only did this contribute to the lack of awareness at Board level of the problems in the Trust, but it is also apparent that what should have been a powerful means for staff to raise concerns was effectively removed from them.

Serious Untoward Incidents

69. Serious Untoward Incidents (SUIs) are a most important part of the incident reporting system that all trusts are expected to have. Their significance is that they must be individually reported to the strategic health authority. An SUI was defined in a Trust policy of March 2007 as follows:

An accident or incident when a patient, member of staff (including those working in the community), or member of the public suffered serious injury, major permanent harm or unexpected death (or the risk of death or serious injury)

on either premises where health care is provided, or whilst in the receipt of health care;

Any event where actions of health service staff are likely to cause significant public concern;

Any event that might seriously impact upon the delivery of services and / or which is likely to produce a significant legal, media or other interest and which, if not properly managed, may result in loss of the Trust's reputation or assets.

70. There is evidence that, certainly before the March 2007 policy, staff were not clear whether an incident qualified to be reported as an SUI. Indeed, the case outlined earlier in this report of a young man who died following discharge from A&E was not, to the Inquiry's knowledge, raised as an SUI. I was told by the Head of Legal Services that when she arrived in May 2006, there were a number of cases considered at inquests which had not been reported as SUIs when they should have been. She attributed this to a lack of understanding. This was confirmed by Dr Suarez, who started as Medical Director in September 2006:

I felt that there were weaknesses in the way that the Trust dealt with Serious Untoward Incidents. I do not think that we were very familiar with it as an organisation. There were weaknesses in our system for example: clinicians did not report incidents as Serious Untoward Incidents; and the categorisation of what was or was not a Serious Untoward Incident was not perhaps sufficiently clarified.

71. While the Inquiry has been assured that reporting of SUIs has now improved, the evidence received gives cause for doubt. In the patient experience section, a case of an elderly woman who experienced a number of falls is highlighted. On examination, the incident report forms that were filed were inaccurate and misleading. The last fall appears to have led to her death, but there is no SUI report. A number of witnesses now accept that this incident should have been reported as an SUI.

Comments

72. The HCC commented on incidents, including inquest cases, which were not reported as SUIs. It also noted the absence of a robust mechanism to ensure that recommendations resulting from investigations were followed through, and found insufficient evidence of serious discussion about these reports at senior level. The evidence received by the Inquiry is consistent with these concerns.

Complaints

73. Effective handling of complaints is an essential part of governance. Most importantly, they provide a person affected by poor care, or by other deficiencies in service, the opportunity to seek recognition and redress. Complaints provide vital information to the Trust about its performance, and are a valuable source of learning about deficiencies that need to be remedied.

74. The impact that its services are having on patients is probably the most important thing a Trust needs to know. Patients' interests should be its first priority. As is made clear in the introduction to A *Commitment to Quality*[45]:

    In their everyday lives people have the right to expect services which are responsive to their needs, which are delivered to a consistently high standard, which treat them with respect and which provide them with good information. This is a legitimate and reasonable expectation and in this regard health care should be no different to other services provided in a modern society.

75. Where this does not occur, patients and their families must have a right to make that known and to expect the appropriate action to be taken.

The CHI report

76. In its 2002 report,[46] while CHI was critical of some aspects of the Trust's governance, it praised its complaints handling and found evidence that complaints had been used to change practice and improve care for patients. It suggested a need for improvement in informal complaints handling in order to avoid some such complaints escalating into formal ones.

77. From 2003 to 2006, the Board did not interest itself in complaints to the extent that it did not receive reports on them. Therefore, throughout that period, it was unable to monitor, or even be aware of, the most basic information about complaints, let alone maintain the complaints-handling system that had met with CHI's approval or monitor progress on making the improvements it recommended.

[45] DH (June 2001) A Commitment to Quality, a Quest for Excellence: A statement on behalf of the Government, the medical profession and the NHS

[46] Commission for Health Improvement (2002) Report of a clinical governance review at Mid Staffordshire General Hospitals NHS Trust

HCC

78. The March 2009 HCC investigation report presented a rather different picture to that of CHI:[47]

The trust had a high rate of complaints compared to other trusts and also high number of patients and relatives who were dissatisfied with the trust's response. Managers did not appear to be aware of these signs of systemic problems. The investigation and the handling of complaints was poor and when action plans were produced, action often did not follow. No mechanism existed for the board to ensure such commitments were met.

79. In fact, the Acute Hospital Portfolio Review for 2004/05 had found that the Trust had the worst complaints record locally, and the second worst for small trusts outside London.[48]

80. The current Chief Executive, Mr Sumara described what he found on arrival in his customary blunt fashion:

A complaints process that was both mechanistic and defensive but was absolutely useless.

Legal framework

81. It is unnecessary to recite the legislative requirements in detail, but it should be noted that regulations[49] impose a requirement on NHS trusts to make arrangements for the handling and consideration of complaints, and that they be dealt with *"speedily and efficiently"*, as well as *"courteously and sympathetically"*. Trusts are required to designate a director to ensure compliance with the arrangements and that actions be taken in the light of the outcome of an investigation. The complaints manager is required to investigate complaints to the extent necessary and in a manner most appropriate to resolve the complaint efficiently. Guidance states that trusts will want to ensure impartiality in investigations. Responses must be signed by the Chief Executive and be "*clear, accurate, balanced, simple, fair and easy to understand*". The importance of learning lessons from complaints is emphasised.

[47] Healthcare Commission (March 2009) *Investigation into Mid Staffordshire NHS Foundation Trust*, pp. 132–133

[48] Healthcare Commission (March 2009) *Investigation into Mid Staffordshire NHS Foundation Trust*, pp. 37, 95

[49] *Local Authority, Social Services and National Health Service (Complaints England) Regulations 2009*

The Trust's complaints policy

82. The Trust's policy went through a number of changes during the period under review, as changes were made to the clinical governance system. However, it is to be noted that all versions of the policy contained the following unexceptional statement:

The Chief Executive has overall responsibility for the effective management of formal complaints, however the Trust Board also has responsibility for ensuring that the organisation has a robust process in place for complaints management and the culture of the organisation (i.e. its behaviour) supports its effective implementation and ongoing use... When things go wrong, then the Trust must ensure that corrective action is taken to improve practice rather than to apportion blame and take punitive action... The Chief Executive has overall responsibility for the management of formal complaints and together with the Trust Board, Directors and Divisional Senior Management Team is responsible for ensuring that lessons are learnt and the standard of care and treatment afforded to patients, carers and relatives is improved following the investigation of a complaint.

Complaints investigation

83. The customer services manager, who was the statutory complaints manager, received complaints and then arranged for their investigation by the appropriate division. A complaints investigator would compile a report for the manager who would then prepare a letter for the Chief Executive to sign.

84. One difficulty with this system was that the investigation would often not be undertaken by an impartial investigator. It was common for the person given this task not only to be in the division where the cause for complaint had arisen, but it would often be someone who worked in the area or ward concerned. The identity of the investigator is disclosed in each report, a copy of which would generally be forwarded to the complainant with the response letter. The appearance of partiality is unfortunate, because it reduces the confidence of the complainant in the thoroughness and objectivity of the investigation. In addition, it is clear from an examination of many responses that a lack of impartiality led to an inappropriate or incomplete response.

85. For example, in one case I was shown, a complaint was made about the attitude of a ward manager in July/August 2007 to a suggestion that his medication had not been changed. The same ward manager undertook the investigation of the complaint. Her report was defensive, and, even though modified by the complaints manager before being released to the family, left them dissatisfied. The report left unresolved disputes about factual matters involving the

investigator, and merely recited her side of the story. The tone of the report can be judged from the following extracts:

There is little evidence to support the comments regarding the call buzzers being left unanswered for periods of over an hour... Every effort is made to answer the bells quickly. However sometimes the patient is asked to wait depending on the urgency of the request. Due to nurses being busy. There was however no excuse for [the patient] *to have waited for the toilet particularly due to his continence problem he should have been prioritised for assistance and for the lack of this an apology is warranted.*

I do not deny that I questioned the fact that his insulin had been changed however I made immediate efforts to respond to the findings following our discussion and with the support of the diabetic nurse [the patient's] *insulin was changed back to his original. I apologise that I did not formally give [the complainant] an apology at the time but I did reiterate to her and* [the patient] *and his wife to continue to inform myself and the rest of the staff should they have any other concerns.*

86. The family disputed that the ward manager had acted as she claimed. Their view was that it would have been more appropriate for the investigation to have been conducted by someone who was not involved in the subject-matter of the complaint.

We were concerned about my grandfather, and the person responding to the complaint is – obviously has a difference of opinion, but it would make more sense to me that an independent person investigates. Certainly that is what would happen in my job and I am sure it would happen in lots of other professions as well.

87. The Customer Service Manager agreed:

If I were setting up an ideal system where I was seeking investigators now, what I would like to see is investigating officers from one division, investigating the opposite division, so it was totally independent.

88. A different view was expressed by a nurse who had investigated a different complaint on another ward:

We have tried it both ways... I have done investigations for A&E, EAU [emergency assessment unit] *and so on. It was very hard trying to get staff to talk about the care that they had provided. For me it was much easier going to the staff on the ward* [where I work] *and saying you have provided – Mrs X here has complained about the care that you have given to her mother, tell me what happened. I have*

got access to off duties; I can access the case notes; I can access the care plans very quickly; I can talk to relatives, if you make a complaint, you don't have to wait for somebody two or three weeks down the line to give you a call.

89. I have no doubt that the advantages proposed by this nurse are outweighed by the disadvantages; the regulations require an impartial investigation, and a well-trained and fair investigator should be able to obtain the necessary information from staff and records without being close to them in the working environment. Promptness is required in any event, and was not always achieved even without using an independent investigator. The guidance which took effect from April 2009 confirms this:[50]

    For serious complaints, it may be necessary to involve an independent investigator, but most complaints will be looked into by someone from the organisation involved.

    Anyone who carries out an investigation should be appropriately trained and independent of the service being complained about.

90. It is worthy of note that the 2009 regulations only require that the investigation be carried out:[51] *"in a manner appropriate to resolve it speedily and efficiently."*

91. The guidance is to be preferred.

Inadequate responses to complaints

92. Many of those contacting the Inquiry with criticisms of the service received had lodged complaints. As a result, the Inquiry was able to see for itself how the Trust had responded to many of the concerns raised. On a number of occasions the substantive response came far too long after the complaint was made. While some issues raised were complex and needed time for a well-thought-out response to be prepared, the delays were not always justified by that.

93. Sadly, it appeared that there was a preoccupation with process rather than substance. There was often a formulaic approach which set out a complex and sometimes technical narrative of the treatment and management of the case without addressing any of the specific complaints made, or ignoring issues which were obviously important to the complainant. Sometimes the nature of the complaint, although clear on careful reading, was misunderstood. Failure directly to address a complaint in this way can give the impression that it is being

[50] Department of Health (2009) *Listening, responding, improving: a guide to better customer care*
[51] The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, SI 309, 14

rejected. Again, where there was an underlying dispute of fact between the complainant and a Trust employee, there was a tendency merely to rehearse the staff member's account in a way that implied that the complainant's version of events had been rejected.

94. Many responses included apologies. These were not always well thought out. Sometimes where a factual account appeared not to be accepted, an apology was offered for the perception.

95. Two examples illustrate some of these points:

96. The husband of a patient complained that his wife had not received notification of an urgent follow-up appointment with the consultant after an inpatient stay in the hospital, despite leaving an answer-phone message with the consultant's secretary. The hospital's response was that the consultant's secretary had rung twice prior to the appointment. The husband challenged this, as his telephone system monitored all incoming calls. However, the hospital's further response simply maintained the consultant's secretary's account and did not request to review the monitoring log. The response concluded, *"I feel we are not going to reach a satisfactory conclusion on this issue."*

97. In a case described in full in the patient experience section, the son of a patient who fell three times while in hospital complained to the hospital that, following the third fall, a nurse had responded *"oh bloody shit"* when told about what had happened. The nurse informed the Inquiry that it had never been suggested to her by the hospital that she had used that language. Thus, there had been no investigation of this allegation. When asked about this in the course of her evidence, she did not entirely deny using the expression:

Q: *Did you use the words "'oh bloody shit"?*

A: *I can't recollect.*

Q: *You say you can't recollect, does that mean you might have used them?*

A: *I doubt it because I would not swear in front of relatives.*

Q: *It would be an unprofessional thing to say?*

A: *It would have been a very unprofessional thing to say.*

Q: *It is curious that you say you can't recollect. You don't say you didn't say it...*

A: *I do not think I did.*

Q: *But you might have?*

A: *I may have said it to my colleagues behind closed doors, but definitely not said to* [him] *in front of a group of relatives.*

98. I gratefully adopt the submissions made by Counsel to the Inquiry describing two examples of cases where the response letter failed to address appropriately the complaints made.

Case 1

99. Mr X was admitted to the hospital on 26 July 2007 and died on 3 August 2007. His family wrote a letter of complaint on 22 September 2007 and received a response dated 22 December 2007. The family had a number of complaints, not least that another patient attempted to strangle Mr X while he was in the hospital. Many of these complaints were not answered or even addressed in the response, which instead set out a chronology of Mr X's medical history. For example:

Complaint: 22 September 2007	Response: 22 December 2007
"Dad came out of the fit and the doctor wanted a scan of his brain. Whilst we waited for the scan dad had another fit... the nurse put him on his side and held him for a few minutes then said she would find someone else leaving [his daughter] *to hold her father until his fit was over. This was very distressing."*	*"Whilst in A&E Mr. X suffered a fit. The nurse who was caring for Mr. X at the time completed the relevant observations... Whilst being examined Mr. X had a fit lasting 2 minutes... There is no record of a second fit occurring."*
"Total communication breakdown from A&E to Assessment Ward"	There was no response to this complaint.
"He was in great pain and we had to keep asking for pain relief for him."	*"On the evening of 26 July 2008 Mr. X advised that he was in pain with a headache. The nurse caring for Mr. X documented that she administered paracetamol rectally. Later that night Mr. X received 2 separate doses of a stronger pain killer called Tramadol this was administered intravenously and was effective."*
"We believe the family should have been informed at the time of the incident [the strangling] *and have not been told why this did not happen."*	There was no response to this complaint.

100. Remarkably, although the family also complained that the assault had been allowed to occur, the response failed to address this and simply set out the steps that occurred in the aftermath of the incident, as follows:

During the night of the 2 August 2007 a Healthcare Support Worker was alerted to the fact that a patient had got his hands around Mr. X neck. The other patient involved was dealt with appropriately by Security staff. The on call Doctor was contacted and following examination and review recorded that no physical injuries had been incurred. The Staff Nurse on duty took appropriate action and moved the other patient out of the bay to maintain the safety of the patients. The Staff Nurse then spoke to the Sister when she arrived for duty in the morning to update her on the incident which had occurred.

Case 2

101. Following his mother falling three times in six days while in the hospital, Mrs Y's son submitted a complaint. The investigation and response to this complaint, dated 1 December 2008, was inaccurate and deficient in a number of ways. For example:

Response: 1 December 2008	**Inaccuracy/deficiency**
"31 October 2008:... She was admitted to EAU on 31 October 2008 via Accident & Emergency following a fall at home... Mrs. Y was transferred to ward 10 at 7.30 hours for further care."	In fact, according to the medical records, Mrs Y was transferred to Ward 10 on 4 November 2008.
"2 November 2008: Family found Mrs. Y really confused and not talking sensibly. Family noticed dressing on back of Mrs. Y's head and nightwear was bloodstained. Family had been notified of the fall. Staff completed an incident form."	Having been repeatedly pressed by Mr Y in a letter dated 18 May 2009, the hospital conceded that *"There is no **accurate** completed incident form relating to your mother's fall initial fall on EAU on 2 November 2008"* (emphasis added). In fact, it appears that no incident form was completed regarding this fall.
"1. Mrs Y fell twice on EAU but relatives were not informed: Staff apparently perceived because Mrs. Y sustained no injury after falling and had been reviewed by a doctor, there was no need to alert the family. Unfortunately [Mrs. Y's son] *discovered his mother's nightwear, bloodstained, in her locker and had to ask what occurred."*	In fact, Mrs Y had sustained an injury in the first fall. Her family found her with a compression bandage attached to her head and subsequently discovered her blood-stained nightwear. In the circumstances, it seems the family should have been informed. Further, no explanation or apology was made.

Response: 1 December 2008	Inaccuracy/deficiency
"3. Mr. Y's concern that he was being informed his mother was trying to mobilise independently despite previously being immobile: As aforementioned, time should have been taken to explain Mrs. Y's medical condition and the issues relating to confusion. A FRASE (procedure for assessing patients who have sustained a fall) assessment form had been completed appropriately but despite staff being attentive Mrs. Y still fell."	While it was true that a FRASE had been completed, the medical records show that it was not completed until after the second fall. This was despite Mrs Y being admitted with a history of falls.

102. Mrs Y's son, before to receiving this report, requested copies of the medical records and incident forms relating to the accident. Dissatisfied with the response from the hospital, he requested copies of all the statements completed by staff arising from the investigation of his complaint. Thereafter he had a meeting at the hospital on 11 February 2009. However, he continued to have concerns about the accuracy of the incident forms (further details of which are set out below) and persevered in his search for clarification. On 9 April 2009, the hospital conceded that the incident forms were inaccurate, sought to explain the errors and provided further copies of the incident forms. Still dissatisfied, Mrs Y's son raised the issue a further time with the hospital which ultimately conceded that the three incident forms contained misleading and inaccurate information.

103. The complainant explained his position on the obvious inadequacies of the responses to his complaint in measured and dignified terms:

Every time they have sent me an incident form, I have found them very difficult to understand, and I have had to go back time and time again, because they can't, or they couldn't see what I was saying was correct... I am just an ordinary person dealing with my mother's death, trying to come to terms with my mother's death and trying to find out exactly what happened – if I can't understand it, I expect the hospital authorities to be able to tell me what happened.

104. It has to be recognised that dealing with complaints where there is a dispute of fact is difficult. The Customer Services Manager said that in such circumstances the Trust generally favoured the account of the complainant unless it was contradicted by the records. However, the Inquiry saw many complaints where this is not what had happened in the response. In any event it is not a satisfactory approach. Without an investigation, unreliable or inaccurate notes may be allowed

to prevail. Equally, an automatic preference for the recollection of the complainant may be unfair to the staff complained against. What is required is an objective investigation. If it is not possible to resolve a factual dispute this should be made clear, but where such an explanation is felt to be necessary, it should also be made clear that it does not mean that the Trust has rejected the complainant's recollection or that there is not a matter of concern to be followed up. Again, the new guidance is constructive:[52]

When areas of contention have been found, most investigators have three basic choices:

- to uphold the view of one party because this is clearly supported by the evidence
- to request additional information to explore the matter further
- to decide that the available evidence will never be conclusive.

The investigator normally works through all the points of contention until they have reached a considered view on every aspect of the complaint.

Remedial action

105. Many responses were accompanied by action plans. Some of these were superficially impressive documents. They purported to define action to remedy at least some if not all of the deficiencies complained about. Such plans looked less impressive when compared with others drawn up in response to similar, subsequent, complaints. It is clear from them that the deficiencies originally complained of had not been remedied, and the 'new' action plan often repeated many of the same points. This suggests that such plans were little more than window dressing and did not in themselves provide any assurance that remedial action had actually been taken. This is not surprising: I was told that ward staff were not informed of the outcome of a complaint and that action plans were not shared with them.

Information from complaints

106. Almost all responses to complaints seen by the Inquiry were personally signed by the Chief Executive. I heard that the letters were drafted by the Customer Services Manager following an investigation. They were reviewed by the Trust solicitor and company secretary before being submitted to the Chief Executive for signature. It is to clear from the evidence the extent to which he actually read them before signing them. If he did so, it is difficult to understand how he could fail to have come to a rapid undferstanding that there were systemic failings in the standard

[52] Department of Health (2009) *Listening, responding, improving: a guide to better customer care* p. 4

of care being delivered in some parts of the Trust. There are letters which, in the context of a single complaint, acknowledge multiple failings. There are others where it would appear he was misinformed: for example, the letter in which he stated that *C. difficile* was not passed on by contact.

107. There is no evidence that the substance of any complaint was ever raised with the Board. They received figures divided into uninformative groupings. To be told that there have been *x* number of complaints about basic care does not indicate whether these are trivial matters or whether they relate to some of the appalling incidents described earlier in this report. If the Board had been told the substance of at least some of the patients' experiences, it is unlikely that directors would have been as shocked as they were when, finally, they heard accounts from some complainants at the Trust's governors' meeting in March 2008.

Speed of response

108. The Inquiry learned of many complaints where the response was made well outside the time limit of the regulations then in force (20 to 25 working days). Two examples illustrate the sort of delays complainants had to put up with:

Case 3

109. The daughter of a patient made an initial complaint on 13 August 2007 (the 'First Complaint') and a further complaint on 21 November 2007 (the 'Second Complaint'). The response to the First Complaint was dated 13 September 2007 but not received by the complainant until February 2008. No response was received to the Second Complaint, so the patient's daughter attended the Patient Advice and Liaison Services (PALS) office on 27 June 2008 and asked to be contacted the next day. No contact was received, and the patient's daughter rang again. She rang for a third time on 4 August 2008 following which a meeting was arranged with a nurse on 14 August 2008. Thereafter the hospital engaged with the complainant, providing an action plan in response to the complaint; this was over one year after the initial complaint was made.

Case 4

110. The son of a patient made an initial complaint on 30 March 2007. The family had a meeting with a nurse at the hospital on 5 April 2007 and received a letter in response to that meeting on 10 April 2007. A formal response to the family's complaint was received on 6 May 2007. The family was dissatisfied with the response and had a further meeting at the hospital on 8 June 2007 at which it was agreed that an independent report would be commissioned into the patient's care. A nurse who worked in the hospital but not on the ward in question completed a further report on 31 September 2007. The family remained

dissatisfied with that further report and informed the hospital on 13 November 2007. The hospital responded on 26 November 2007 referring the family to the HCC. Following unsuccessful attempts for a meeting between the family and the hospital, on 9 March 2008 the family contacted the HCC. On 17 September 2008 the HCC upheld the complaint and referred matters back to the hospital for a further response. The hospital produced a further report on 25 November 2008 which included an action plan. The family, despite requests, did not receive the action plan. A further meeting was arranged with the hospital on 28 January 2009 following which the notes of the meeting were not agreed between the hospital and the family until 17 March 2009; this was just under two years after the complaint first was made.

111. There are, of course, cases where the matter is complex to investigate and requires time, but it must always be remembered that the longer the process takes, the more difficult it will become to resolve the complaint and the less likely it is that the complainant will be satisfied.

Impact on complainants

112. Many complainants, whether they are patients themselves, or, as was often the case with witnesses to the Inquiry, grieving relatives of deceased patients, will have been traumatised by the experiences of which they complain. It was evident that many of those who summoned up the courage to come to an oral hearing remained deeply distressed by what they had gone through, even when the events they were recollecting took place some years ago.

113. One family told me about how stressful they have found the complaints process, especially where it had left them dissatisfied with its outcome:

Obviously the last thing you want to be doing when you have lost somebody is to be doing anything like this. This is traumatic enough as it is, but I was determined I wasn't going to let it go...Well, it is very stressful and emotional and it is hard to look at things objectively.

Q: *Do you think those that are meant to be dealing with these complaints up there actually understand that?*

A1: *No, I suspect not. I think you have got to – I think you have got to have seen or experienced in some way those kinds of things. I wouldn't wish anybody to go and experience that.*

A2: *The last thing you want to be doing when somebody has died is to cope with all this, but if it had been the other way round and it had been me, my father would have moved heaven and earth.*

114. Receipt of an apology accompanied by a suggestion that the complainant is wrong may merely serve to increase the sense of grievance. Failure to offer a prompt and full acknowledgement of the wrong done to the complainant and his or her family can cause real distress and even harm. Bereaved families are unable to find closure to their ordeal; often they battle with quite unjustified feelings of guilt that they could have done more to save their loved one from what happened. Some of those I have seen and whose letters I have read harbour a belief that the patient with whom they are concerned met with an avoidable death because of the lack of care. They remain desperate for answers to their questions from someone whom they can trust. The failure to meet these reasonable expectations through an effective complaints process exacerbates and prolongs bereavement, and distressing memories and may result in deeply entrenched attitudes and beliefs that cannot be shaken by any form of evidence showing that no harm was done by poor care, no matter how persuasive. In short, a defective complaints process in the health service has far more serious consequences than bad customer service in the retail industry. It can harm the very people it is designed to assist.

Reporting and analysis of complaints

115. Before 2005 the Trust had a system for monitoring and analysing complaints which appeared to ensure that non-executive directors were given a detailed account of individual complaints as well as the trends derived from analysing them collectively. A quality effectiveness committee met on a monthly basis and there were also complaints review panels (for example, a clinical standards panel and a medical directorate panel) that met on a quarterly basis. These panels reviewed all the complaints received by their respective directorates or divisions and, importantly, their membership included a non-executive director. It was explained that the panels discussed trends and would recommend additional actions that needed to be taken.

116. In 2005 the former Chair, Ms Brisby, and the then Chief Executive, Mr O'Neill, abolished the review panels. Ms Brisby was dismissive of them; she did not consider that it was the role of non-executive directors to concern themselves with details:

That committee sounds like a really good idea and didn't do anything; nothing came out of it and it seemed to me that it conflicted with the role of the non-executive, because the role of the non-executive is actually not to get into detail, not to get into the operational detail and most of the complaints were about operational detail.

117. The Customer Service Manager, however, told me that it was her recollection that the panels were abolished because they led to too much time being taken up at Board meetings discussing complaints.

118. From 2006 complaints were reported on a quarterly basis to the Integrated Governance and Risk Management Committee (or, from 2007, the Executive Governance Group)] which in turn reported to the Audit Committee. This committee's minutes were tabled at Trust Board meetings, although they include little mention of complaints during this period. From the third quarter of 2006, the Trust Board itself did start to receive an analysis of complaints on a quarterly basis. I am indebted to Cure the NHS for an account of these reports, which is appended to this report (Appendix 8). It will be seen that the analysis identified many of the themes which are so apparent in the accounts described in the patient experiences section, including concerns about Wards 10 and 11, A&E, basic care issues and communication. There is, though, no evidence of any effective action being taken to find out what lay behind these trends and to address the causes.

119. This serial filtering of information about complaints without the involvement of non-executive directors any lower down in the hierarchy of committees inevitably distanced the Board from the reality of what they showed. The Inquiry has analysed a collection of reports from these committees and found a pattern which raises concerns:

- no details were provided as to the content of any complaint;
- no information was collated as to whether complaints about particular wards or areas were being repeated;
- no reports were made on the progress in implementing action plans and recommendations; and
- statistics divided complaints into groups or categories, such as 'cleanliness' and 'communication', which give little clue as to the underlying gravity or substance of the complaints involved.

120. The Audit Committee did request more details about numbers, categories and other information to enable it to understand whether any trends existed, but did not succeed in drawing out information which would have alerted it or the Board to the gravity of the situation.

121. That the system adopted totally failed to detect real problems is shown by the bland nature of the review of emergency care undertaken in March 2008. Shortly afterwards, in May 2008, the HCC wrote to the Trust expressing serious concerns about A&E and suggesting that urgent corrective action was required:

The evidence reviewed has highlighted an increase in the number of complaints relating to A&E during the refurbishment and this will continue to be monitored through the Divisional Governance Groups on a monthly basis and on a quarterly basis at the Executive Governance Group to ensure that this reduces as anticipated.

122. The need for Board members to be made aware of the substance of complaints is now appreciated by at least one former non-executive director. Mr Bell told me:

It has been suggested that the Board should consider serious complaints in depth themselves. I do not totally agree with that but I think a mechanism does need to be found whereby the most serious complaints are investigated by some sort of independent body, whether this is partly non-executive directors or somebody else and that then the concerns are brought to the board. We didn't have that in operation and that would certainly have given us some pre-warning. I have actually already been asked by a non-executive director in another trust: what do we do to avoid the problem you have had? One of the first things I have said to him is: just make sure that you have got some real process on complaints because you really need to know about them if there are serious things going on.

Follow-up of action plans

123. There was ample evidence that follow-up of action plans was sporadic, at best. The Head of Governance, when asked to provide evidence of the implementation of five action plans arising out of complaints seen by the Inquiry, could find no evidence that any action had been taken. Indeed, it appears that the primary purpose of such plans was to satisfy the complainant, not to initiate action. She was asked:

Q: *Without appearing to be flippant about it, was it a matter of luck, really, as to whether or not any particular action plan was or wasn't implemented?*

A: *Yes, I think individual action plans were a problem that were identified as a result of individual complaints... The divisions certainly weren't monitoring them at their governance meetings and the wards, I do not believe – there was no evidence to support that they were looking at them and taking the action that they had identified...*

Q: *Your view was that it would be fruitless to try and track through action plans from any particular complaint because you simply wouldn't be able to tell whether the action had been taken or not.*

A: *No*

124. That the action plans were not used was confirmed by a sister who had charge of Ward 10. When asked about the action plan resulting from a serious complaint (referred to as case 2 above) she made it clear that she had never seen it. This complaint included concerns about a frail and vulnerable patient who had sustained two falls in EAU in 2008 before a risk assessment (FRASE) had been completed, and with no incident form having been made in respect of the first fall.

125. It is clear from the occurrence of these deficiencies outlined in case 2 above, which took place in 2008, that the action plans from three earlier incidents (summarised below) were not followed through. The same problems arose again.

Case 5

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

Case 6

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

Case 7

128. The patient had fallen out of bed in the EAU and the family had not been informed. A complaint was made on 4 September 2007 and the response was completed on 8 October 2007, including an action plan that stated staff were to inform relatives when falls had occurred, should complete an incident report and utilise FRASE.

129. The Customer Service Manager, who described the system swept away in 2005 as *"the best model ever"*, proposed a return to a similar model in May 2008. Complaints review panels were reinstated in March 2009 but I understand that non-executive directors still do not sit on them.

Comments

130. An ineffective complaints system does more harm than not having one at all. The complaints system as run by the Trust failed to fulfil its essential purposes of providing complainants with remedies for their grievances and enabling the Trust to improve its service and avoid poor care. Instead of resolving dissatisfaction it often increased it, and arguably caused significant harm to some complainants.

It resulted in remedial action not being taken; indeed, neither the Board nor front-line staff were aware of the need for it. In reality, there was a triumph of appearance over action.

131. Complaints are a vital tool for effective governance and the system at the Trust must be reviewed to ensure that it fully complies with current guidance. Given the loss of public confidence in the Trust as a result of the events leading to this Inquiry, a more than usually robust and transparent system is required.

Staff support through appraisal and professional development

132. Weighed down as this report is by the terrible stories of bad nursing care, it must be remembered how important and challenging the role of a nurse is and how much support and respect good nursing deserves. As was said in a report in 1999:[53]

People rightly hold nurses, midwives and health visitors in high regard. They see them as forces for good in our society. They look to them, as well as to others in the NHS, for help at times often of great difficulty for themselves, and for their families. People trust them, They have confidence in them – in their skills, in their abilities, in their commitment. People see nurses, midwives and health visitors as important, as special, as vital. They are right to do so.

133. The same report reiterated the need for a commitment to continuing professional development as essential to the introduction of clinical governance and continuous quality improvement, and supervision:[54]

The learning that takes place at work through experience, critical incidents, audit and reflection, supported by mentorship, clinical supervision and peer review can be a rich source of learning.

134. The annual national staff survey indicated a persistent cause for concern in relation to the incidence of appraisal, training and job satisfaction in Stafford. The findings are presented in the following table.

[53] DH 2009: Making a difference – Strengthening the nursing, midwifery & health visiting contribution to health & health care

[54] Ibid., p. 30, paragraph 4.20

FIGURE 1

Period	% Appraised	Relative Position	% Receiving Training	Relative Position	Job Satisfaction	Relative Position
2005	49	Lowest 20%	90	Lowest 20%	3.29	Lowest 20%
2006	44	Lowest 20%	65[55]	Lowest 20%	3.32	Below average
2007	47	Lowest 20%	73	Lowest 20%	3.24	Highest 20%
2008	80	Highest 20%	81	Average	3.43	Average

135. While there was a clear improvement in all three areas in 2008, it should be noted that only 29% of staff thought that appraisals were well structured, even if this was better than the national average for acute trusts.

136. The perception that training had not been a priority was endorsed by Dr Helen Moss, who joined the Trust in December 2006. She told me:

there wasn't any real evidence of training for nursing in the organisation. It was quite limited. The training budget year on year had been underspent and hadn't been utilised... the nursing staff didn't really have defined plans, although there was some education that was happening.

137. This suggests that whatever the figures were for some form of training being provided, it may not have been very well organised.

138. The former chairman of the consultant staff committee also observed that there had been a lack of training culture in the organisation:

One absolutely vital issue is in relation to training, and my feeling is that the Trust has not had a culture of learning and that insufficient emphasis has been placed throughout on training issues. I mean, it has been far too easy to say, no, you can't go away for a training session because we are short on the ward... I mean, after all, 2,000-odd people are nurses, and if they say: can I go on a training day, the answer is: I am afraid things are too tight on the ward, it is winter, there is a flu epidemic, and too often the answer has been no. And this is reflected to some extent in that if you look at statutory training, I mean training that everybody has to do and what do we score? About 43 per cent.

[55] This was a different measurement to the previous year

139. As is at least superficially apparent from the survey figures, attempts were made to improve the position after the arrival of Dr Moss. She proposed a training plan after completing an organisation-wide training needs analysis. A post of clinical skills trainer was created and filled. How effective this was is open to question. The Inquiry asked the Trust to produce information about the number of nurses, and healthcare support workers, agency and bank staff in Wards 1, 2, 6, 7, 10, and 12, A&E and EAU who had completed induction and mandatory training since 2005. Owing to IT difficulties, the Trust was only able to provide figures for 2007/09. In its response to the Inquiry, on this question the Trust said the figures revealed *"inconsistent completion of induction and statutory/mandatory training in 2007-9... indicative of an insufficient focus on this area in the past"* and stated that steps were being taken to address this deficiency.

Comment

140. While it is clear from the national staff survey figures that the Trust is not alone in having issues to address in relation to appraisal and training, it is an absolutely vital matter in an organisation which has been suffering from the cultural and organisational issues exposed by the HCC and this Inquiry. There is an urgent need to turn around staff morale, attitudes and professionalism. One essential step in this is to prove to them that good practice and professional development are valued, as are the staff who adhere to appropriate and caring standards.

Discipline

141. While disciplinary measures should be a last resort, no prudent management can hesitate to implement them when patient safety and welfare are at stake. Some of the behaviour described by witnesses – both hospital users and staff – should have attracted disciplinary action. As described earlier, there were generally low levels of formal discipline at the Trust. The section on Trust Culture sets out two cases where disciplinary action was likely to have been justified in the interests of protecting patients. These included:

- staff who were alleged to have encouraged the fabrication of A&E records
- the case of the consultant subject to an SUI involving the perioperative death of his patient.

142. This SUI was part of the subject matter of the reviews of the Surgical Divisions, which are worth more detailed examination with regard to the Trust's disciplinary processes. In the summer of 2007 the Royal College of Surgeons was invited to conduct a review of the general surgery service, with specific reference to colorectal and laparoscopic cholecystectomy services. Concerns had been expressed about the complication rates in this area; the practices of certain individuals and their relations with each other; and the emergency service for

general surgery. In part at least, the request for the review had been triggered following an approach to the then Medical Director, Dr Gibson, by a consultant who raised concerns about a colleague. The consultant suggested to us that nothing was done initially, but that when Dr Suarez took over and the consultant repeated his concerns, the Royal College review was requested.

143. The Royal College team produced its report in October 2007, and amended it in June 2008. It concluded that the department of surgery was *"somewhat dysfunctional"* and that it lacked effective clinical leadership. A number of the surgeons who attended the Inquiry agreed with this conclusion. The Royal College's report confirmed that there were some concerns about the practices of certain individuals and relationships between individuals. It suggested that the functioning of the department was prejudiced by the poor working relationships between consultants:

    There is no cohesion within the department, which makes it very difficult for other members of the team to function in a satisfactory way. This is illustrated at the multi-disciplinary team meetings where discussion and decision-making are compromised by disagreement.

144. For example, the relevant consultants could not agree on common protocols for particular procedures. The review considered this a very serious matter:

    Unless this is addressed urgently, the unit will disintegrate further and the situation may become irredeemable. No doubt these surgeons are well meaning, but both lack a degree of insight into their own personalities and the way their actions and interactions affect others around them.

145. The Trust's response was to organise psychological profiling for the relevant consultants, who reluctantly submitted to it. One of them thought that it was an interesting experience but that it did little to help the situation. Having seen both consultants at the oral hearings, it is clear that if they agree on anything it is that relationships are no better than they were.

146. The clinical lead for surgery told me that the Trust was at loss what to do:

    Issues were brought out into the open. I felt very strongly that we as a department were not kitted out to cope with it, and we had to look to the Trust to resolve this for us. But I just fear the Trust too was equally all at sea about how to cope with situation as we were in the department, in the surgery.

147. It appears that the Trust took no further action about this until two SUIs occurred in 2009, one of which has been mentioned above. Then in October 2009 a further review was requested, and a report was produced in December 2009. The Trust

has not seen fit to share a copy of this report with me, but from the evidence received it was extremely critical of the department. It expressed the view that the surgical department cannot be allowed to continue as it had, and that idiosyncratic practices should not be allowed to prejudice the provision of safe care. At least as a matter of inference it would appear that the review is saying that the department was not safe. If this is an exaggeration of the actual text, then that is due to the Trust not showing it to me. What is known is that a number of recommendations were made, including:

- removal of breast surgeons from the on-call rota;
- steps to address the behaviour and competence of colorectal surgeons;
- a review of the role of vascular surgeons;
- appointment of an upper gastrointestinal surgeon and one colorectal surgeon; and
- steps to address issues of team working.

148. I understand that the Trust has now taken steps to:

- restrict breast surgeons from undertaking colorectal surgery;
- require laparoscopic cholecystectomy to be performed by pairs of surgeons, overseen by a surgeon from elsewhere; and
- restrict laparoscopic cholecystectomy to one surgeon.

149. I also understand that temporary restrictions have been placed on the practice of one surgeon, pending further action.

Comment

150. It is important to understand that the Inquiry has not, and could not, come to a fair conclusion on the substance of the concerns raised by the Royal College's reviews in relation to individuals. Understandably, most if not all of the adverse criticisms of individuals made by the reviews have been challenged by those individuals. Having heard evidence against them they would be entitled to put forward a full case before conclusions could be arrived at fairly. In one case the practitioner has alleged that he is being victimised. It is important therefore that there is a fair process adopted, and this Inquiry should not interfere in that. However, it is of concern that issues about individuals which were raised in 2007 have still not been resolved today. Issues arising out of interpersonal conflict are always difficult to resolve, but doctors are subject to a code of conduct requiring them to work constructively with colleagues. Where there is a failure to do that, robust disciplinary measures may be justified. What cannot be allowed to happen is that a problem which is prejudicial to the welfare of patients is allowed to continue.

Whistle-blowing

151. It has already been noted that staff filing incident reports which raised concerns about staffing levels were in some cases discouraged from doing so. Another form of raising concern available to staff is what is loosely known as 'whistle-blowing'. This can take many forms, including passing information to management or colleagues within the same organisation or, in some cases, to some external body or individual or even the media.

152. It has been public policy for a long time that individuals raising concerns about their organisation in good faith should be protected when they do so from victimisation or adverse employment consequences. In 1997 the then Minister of State, in an open letter to NHS trusts,[56] expressed the wish that employers encourage *"a climate of openness and dialogue, where staff's free expression of their concerns is welcomed as a helpful contribution towards improving services to patients"*, consistent with the requirements of patient confidentiality. At the same time a 'dear colleague' letter was sent by the NHS Executive to all NHS trusts.[57] This might be thought to have restricted somewhat the *"openness"* referred to by making it clear that staff were to be *"encouraged"* to raise concerns with their management, and only to use other avenues when there were *"well founded reasons"*. In 1999 the Public Disclosure Act 1998 became law. This accorded statutory protection to workers (which includes employees) who raised concerns which in their reasonable belief tended to show, among other matters, that the health or safety of any individual has been or is likely to be endangered. The legislation is complex, but there is a great deal of guidance available.[58] Essentially, protection is afforded to employees who raise with their employer a matter of concern about the health or safety of an individual, among other matters, while reasonably believing that the information they wish to pass on tends to show, for example, that malpractice has occurred. There is an additional requirement in obtaining protection for wider disclosure to regulators, whereby the employee must reasonably believe the information to be substantially true. Disclosure to the media or a Member of Parliament can be protected for the following reasons: the employee must reasonably believe that they would be subject to a detriment if they raised the matter internally or with a regulator; there is no prescribed regulator and the employee reasonably believes that the information would be concealed or destroyed; the concern has already been raised with an employer or regulator; or the concern is exceptionally serious.

[56] Letter to chairs of NHS trusts and health authorities from the Rt Hon Alan Milburn MP, Minister of State at the Department of Health, 25 September 1997

[57] Department of Health (25 September 1997) Circular misc (97) 65: *Freedom of speech in the NHS*

[58] For example: BMA (2009) *Whistleblowing: Advice for BMA members working in NHS secondary care about raising concerns in the workplace* and the Public Concern at Work website at www.pcaw.co.uk

153. The Trust has had a policy on whistle-blowing since 2001. The 2008 version contains the following statement:

The aim of the policy is to encourage staff to raise concerns about possible malpractice in the Trust at an early stage and in the right way.

The Trust Board will take all such claims seriously and is committed to developing a climate of openness and free expression whereby concerns about the delivery of patient care, financial malpractice, or other wrong doing is welcomed, appreciated and acted upon positively. The Trust Board will take all reasonable steps to protect those raising concerns in accordance with this policy, and will, as far as reasonably practicable; respect their request to protect their identity and to maintain their confidentiality. Such information will only be disclosed in exceptional circumstances following consultation with the individual and with their written consent.

Any claim of malpractice made falsely or maliciously would be construed as a disciplinary offence. Similarly, the bullying, isolating or victimising of anyone making such claims in good faith, or deterring anyone from reporting such matters, would also be construed as a disciplinary offence.

154. The policy also contains a list of responsibilities. Those for staff include the following:

- *ensure that the best standards of care are achieved*
- *report any concerns that something is happening which might compromise this standard to a member of the Trust as outlined in this procedure*
- *raise concerns in good faith with a true belief that a malpractice has occurred*
- [to] *not raise concerns with a malicious intent.*

155. This appears to be more restrictive than the Employment Rights Act 1996, which requires only that the whistle-blower has a *"reasonable belief"*, rather than the *"true belief"* of the Trust's policy.[59] The additional requirements of good faith and a reasonable belief that the information disclosed and any allegation contained in it are substantially true only arise in respect of a disclosure other than to the employer or regulator. This discrepancy could deter someone from coming forward with credible information that they have received but are personally unable to verify.

[59] Section 43B of the Employment Rights Act 1996, as inserted by the Public Interest Disclosure Act 1998

156. The responsibilities of Trust managers under the policy include the following:

- take staff concerns seriously
- consider them carefully and undertake an investigation
- take prompt action to resolve the concern or refer it to an appropriate person
- keep the member of staff informed of progress
- monitor and review the situation
- ensure that individuals who report concerns are not penalised in any way.

157. I was told by Norma Sadler, former Director of Human Resources, of the steps taken to promulgate the policy to staff:

There was a whistleblowing policy in place round about 2001. It was very clear what the process was because at that time it was agreed by the board that the main contact for whistleblowers would be myself initially and a non-Executive Director. Then that was changed to be myself and the chair of Trust. It was communicated to staff what the whistle blowing policy was. There were posters put up on notice boards saying who the contacts were and my mobile number was included on that, as was the chairman's and the non-executive's. Every member of staff was given a credit card size document laying out what whistle blowing was about and who they could contact. Every new member of staff was given one of these credit card size documents and it was on the Trust induction programme. So it was very well publicised. I do not think I could have done much more than I did around that.

158. In spite of these efforts and the clear concerns that existed among staff about poor practice, there has been little use of this means of raising them. Ms Sadler told me that there were only 10 incidents in the six years that she was in post (from 2000 to 2006), and that some of these were not in fact whistle-blowing. The Inquiry has been made aware of the facts of only three whistle-blowing reports, which are considered below. The Trust was expressly asked by this Inquiry to produce details of whistle-blowing reports received during the period under review, but it has failed to provide an answer. However, the three cases of which I am now aware all have whistle-blowing connotations and all give cause for concern as to whether individuals who blow the whistle are properly looked after and whether the concerns they raise are properly pursued.

Case 1

159. The first case relates to a consultant who on the 30 of May 2008 submitted a memorandum to the Parliamentary Health Select Committee in which he outlined his attempts over many years to raise concerns. He raised the same concerns with the HCC in the course of its investigation at the hospital. He has repeated those concerns to the Inquiry, and this report reflects what he told me. On 30 March 2009, one day after the publication of the HCC report, he was suspended by Dr Suarez, the outgoing Medical Director, on the grounds of an allegation that he had behaved in an intimidating manner towards a colleague and a patient. One of the first actions taken by Dr Obhrai on assuming the post was to remove the suspension. The Trust's account of why it acted in this way was set out in a letter dated 23 July 2009 to the consultant's Member of Parliament. It said:

    [The consultant] *was excluded from work on 30th March 2009 by the then medical director. She had received an oral report that he had behaved in an intimidating manner...* [and] *there was concern that this behaviour could be repeated as it had occurred on more than one occasion and it was also reported that as a result of the behaviour both the patient and staff had been crying. The exclusion was lifted by the new medical director on 7th April as, following the receipt of statements, there were no grounds for continuing his exclusion, although there were allegations of inappropriate personal conduct which needed to be investigated.*

160. The consultant told me that the new Medical Director had:

    basically told me in my meeting with him that there wasn't enough grounds for him to exclude me from work.

161. However, it was made clear to him that there would still have to be an investigation into the allegation of misconduct.

162. He told me that as of December 2009 the investigation into his conduct had still not been concluded. In the meantime he lodged a grievance and received an oral apology:

    An unconditional apology was offered saying that I was not treated... appropriately, procedures had not been followed, they accepted that they had caused a huge amount of distress to me and to my family.

163. This was followed up by a letter which did not satisfy the consultant because although it offered an unconditional apology it did not in his view sufficiently acknowledge that proper procedures had not been followed.

164. In view of the fact that the disciplinary process has not been completed, I did not pursue the issues of this case with current hospital management. This is because it would be wrong to interfere with a process which is not complete and for me to comment on the merits of the matter. However, it is pertinent to note that there was an unhappy coincidence, to say the least, in the correlation between the timing of the publication of the HCC report, which reflected many of the concerns the consultant told me he had raised many times previously, and his suspension in circumstances which have later been found to be unjustified. The Trust will have been aware that he made a link between his complaints and his suspension, if only from the published evidence to the Health Select Committee. They would also have been aware about that committee's conclusion:[60]

Many healthcare workers remain fearful that if they are open about harm to patients they will be unfairly blamed for causing it; and that if they whistleblow they will be victimised. Where information is available about incidents, it is too often not used to make lasting improvements to services. We have insufficient evidence to comment on the adequacy of statutory protection for whistleblowers. However, the information we have received indicates that the NHS remains largely unsupportive of whistleblowing.

Comments

165. Where such a suspicion is likely to be held, even if it is unfounded, then it is important that any appearance of victimisation is removed, and the grievance involved is swiftly redressed. In this case that must include the prompt and fair resolution of the disciplinary complaint. This is not to say that allegations of misconduct should not be pursued where they are justified – far from it – but it is quite wrong that a procedure over what appears on the face of it to be a relatively minor matter should be allowed to drag on for so many months: It requires fair and prompt resolution. Failure to do so runs the risk of perpetuating the complaint of victimisation and adding to the hesitation others will feel about coming forward with concerns.

[60] House of Commons Health Committee (July 2009) Patient Safety, para 295, London: TSO

Case 2

166. The second case was drawn to the attention of the Inquiry by the whistle-blower, the external investigator and Cure the NHS, but not the Trust. The complaint concerned allegations of poor care in Ward 3 and was made by a nurse and a healthcare support worker. Both had left the hospital, having made the allegations under the whistle-blowing policy at a formal meeting with the Director of Human Resources on 21 July 2005. They raised concerns about the management of the ward and identified particular members of staff. Their concerns, as summarised in the investigation report, included the following:

    - *Poor management of staff* (specifically the use of swearing and aggressive language)
    - *Insensitive handling of staff issues*
    - *Inequitable management of staff based on personal relationships*
    - *Poor patient care, specifically failing to keep incontinent patients clean and dry, failing to change dressings frequently enough, failing to record dressings, failing to keep adequate patient notes*
    - *Poor nursing practice specifically signing for medications before they have been given, covering up mistakes in ordering medications, failing to notify relatives of patient deaths and covering up mistakes*
    - *Lack of leadership and failure of management to identify and manage poor practice (failure of governance arrangements)*
    - *Failure of managers to implement the Trust's professional development policies*
    - *A culture of accepting poor practice as an inevitable consequence of poor staffing ratios.*

167. The former Finance Director, Mr Newsham, who was at that time Acting Chief Executive, along with Ms Brisby, former Chair of the Trust, commissioned an external investigation, in part it seems because the whistle-blowers did not want the Director of Clinical Standards involved. Mr Newsham told the Inquiry that in his time he had been involved in five or six whistle-blowing processes, and that not many whistle-blowers had come forward in his time. He told me that he would have expected that the records of all whistle-blowing reports to have been kept in the Human Resources department. Ms Sadler, the then Director of Human Resources, confirmed that she kept files on formal whistle-blowing investigations in the Human Resources department. Mr Newsham recalled the case concerning Ward 3. He appointed as an investigator a clinician recommended to him by the Director of Nursing of a neighbouring trust. He did not suspend the nurses against whom the allegations were principally directed, he said:

    Basically... because it was felt that it could have been mischievous...

168. Mr Newsham received the report after Mr Yeates took over as Chief Executive, and handed the report to him after he took up the post. He does not know what happened after that. Ms Sadler also had no recollection as to what action followed, if any. Ms Brisby recollects receiving a copy of the report but says that she would have expected it to be considered in detail, and acted upon at the Clinical Quality Group:

I would expect to have passed it on to the Chief Executive and the Director of Nursing and Quality Standards for action. I would then expect a report of this nature to be considered in detail by the Clinical Quality Group, a group consisting of senior clinicians, and acted upon.

Although this was a serious matter, it would not normally have come to the Board because it dealt with operational issues at ward level.

169. The investigator's report, which was handed to Mr Newsham in August 2005, came to a number of damning conclusions. Among them were the following:

- There was evidence that patients were not always properly cleaned, although there was insufficient evidence to implicate any individual staff member.
- There was evidence to support the allegation about the sister's inappropriate and aggressive style of management. It was thought that it was a mitigating factor that she was hard working and dedicated, but that this did not excuse her behaviour or management style. It was recommended that she reflect on her practice and that she receive regular support. Other staff should be alerted to 'non-threatening' processes for reporting such events.
- The evidence was found to support the allegation of ineffective management:

I found a high degree of confusion amongst staff at all levels from Directorate managers down to unqualified staff as to who ws responsible for nursing care... It appears that no one takes charge.

- It was recommended that the sister needed to identify support and training needs.
- It was found that there was a failure to implement annual appraisals and support for professional development: only one set of appraisal documentation was found for the previous year, in relation to 25 members of staff. The report found that the Trust had no mechanism for recoding, monitoring or auditing appraisals, which appeared *"to reflect a system failure"*.
- The investigator found that *"there is a culture on the ward of failing to keep adequate or up-to-date records"*. This included a failure to record pressure ulcers. It was thought that the audit system should have picked this up, and that directorate management ought to have intervened.

- *"Convincing"* evidence was found of a failure to systematically change dressings and to record this.
- There was evidence of a *"lack of systematic provision of nursing care"*. The complaints about basic nursing care were in themselves sufficient to raise concerns.

170. Insufficient or no evidence was found in relation to a number of other serious allegations.

171. In view of the findings made by this Inquiry, it is helpful to set out in full some of the conclusions from this report:

There has been an increase in the death rate.

There is a strong view on the Ward that failings are due to poor staffing levels and therefore excusable. The culture on the ward appears to allow for support of this view.

The investigation has highlighted poor governance arrangements across the Directorate and Trust.

I believe that the problems are due in part to the fact that the Ward is, in effect, an elderly care ward, with very poorly and disabled patients. Yet it does not make elderly care issues a priority. On the elderly care wards prevention of pressure sores, turning patients and changing dressings are high priorities since staff are very aware of their importance in maintaining and improving patient health. This is not the case on ward 3.

Lack of strong leadership has failed to challenge these attitudes... there is a lack of any systematic approach to coordinating care, compounded by very poor communication.

172. Among the recommendations was the following:

The trust needs to acknowledge its role in the failure of its governance mechanisms. In particular that something as important as pressure sores should be led by someone who has the authority to effect change and to act when advice is not taken up. I would suggest a champion at Board level.

173. The Inquiry has been unable to find any Board minutes suggesting that this report was ever presented to the Board, or any other evidence that action was taken as recommended; indeed, Ms Brisby has confirmed that she would not expect the Board to consider it.

174. The investigator, whom I was able to meet, told me that she believed that there had been other members of staff who might have joined the whistle-blowers, but that they had backed out for fear of repercussions. In her view, the failings she had identified had been caused by a failure of management:

Management is there to ensure that these things don't happen, and if they do, to ensure that proper actions are taken in response and that they do not happen again. If that is not happening, things will fail.

175. She found it odd that having submitted her report she received no feedback from the Trust, and was not invited to meet managers or to give a presentation to the Board. The only response was a letter of thanks. However, she acknowledged that a factor in the lack of contact may have been her own absence from work for a period of months.

176. She thought that the general approach to the handling of whistle-blowers (not just at Mid Staffordshire NHS Foundation Trust) is flawed: allegations are often leaked, and this deters people who are afraid of a breach of confidentiality. She considers that the solution is to avoid the need for whistle-blowing at all, by encouraging forums where concerns can be raised at team level, and proper supervision to prevent concerns from escalating.

177. The Inquiry specifically asked the Trust whether any disciplinary action had been taken against a senior nurse referred to in the report. No information about this has been forthcoming. The Trust did, however, provide information indicating that she remained a ward manager until redeployment to another post in November 2007.

Comments

178. Because this episode happened some time ago, investigation of it has proved difficult. It is of concern that the Trust has not been able to furnish any information about the report in this case or of any action which followed. It is also of concern that there appears to have been no discussion by the Board of the serious issues raised in that report – or that they were even made aware of it. It is striking that the investigator's conclusions closely mirror the findings of the HCC and the evidence collated in this Inquiry's report. I am driven to conclude that no effective action was taken on the report into Ward 3, even though it raised serious systemic failings in the management of the hospital.

Case 3

179. The third whistle-blowing incident considered by the Inquiry occurred on 28 October 2007. There was an allegation of falsification of patient documentation in order to avoid the breach of targets in A&E, and a more general allegation against two sisters working in A&E of bullying and harassment. This too was drawn to the Inquiry's attention by Cure the NHS. The Inquiry heard evidence about this incident from the whistle-blower, another A&E nurse (who had provided supporting evidence in the investigation), a matron and Chief Operating Officer. In particular, the whistle-blower alleged that she was pressurised by a senior nurse to falsify a medical record to conceal the fact that there had been a breach of the A&E target, and that she had refused to do this. She made a complaint about this and then supplemented it with a more general complaint that two members of the A&E staff habitually pressurised others to enter false times on records. There were other concerns about a bullying culture among a group of nurses, and about harrassment as a result of the complaint. The two nurses against whom the principal allegations were made were suspended from duty. The Directorate Manager for Surgery was appointed to investigate and a number of interviews took place. A circular letter was sent to staff inviting them to come forward and explaining how this could be done.

180. The most specific, and serious, allegation, was that on a specified date the whistle-blower had heard a senior sister tell another to tell the whistle-blower to lie, after she had reported that patients had *"breached"* the target. The other sister had come back to her and told her that the senior sister's advice was to lie. The whistle-blower confirmed this account in an interview on 4 January 2008. The sister who came out in support of the whistle-blower was also interviewed: she stated that the reasons she had written something was because of the situation for other members of staff. She said that staff had been told to lie abut the four-hour waiting times in order to avoid target breaches and action against them. Historically, she said, it had been accepted practice that times were recorded inaccurately to avoid breaches. She also alleged that an off-site manager had told staff that *"if we wouldn't do it then they would write over it"*. The sister against whom the specific allegation was made denied it at interview, although she admitted that *"she may have made a flippant comment along those lines"*. She asserted that at no time would she falsify records or instruct others to do so. She pointed out that the process was audited and that discrepancies would be investigated. The investigator concluded that there was no case to answer on the principal allegation. Her reasons for this were as follows:

    There is no tangible evidence that [the sister] *intended* [the whistle-blower] *to falsify the breach times, and although it is likely that she made the statement she states she did not intend it to be taken literally. After the initial comment* [she] *did not persist either by phone or in person to insist* [the whistle-blower] *falsify the times and no times were found to be falsified that afternoon. However it is*

clear from their reaction at interview that both Staff nurses were not sure how seriously to take her comment and both stated this was not the first time senior nursing staff had made similar comments...

181. The investigator noted the following, however:

It is clear that the 4-hours waiting target is a source of stress in the department and it is feasible that senior staff may apply pressure to manipulate times and possibly processes to prevent breaches. If as alleged the practice is potentially endemic then managerial action is required to reiterate the importance of adhering to the set processes and the implications of falsifying or manipulating information.

182. A further investigation took place into the more general complaints of bullying and harassment and into allegations of specific incidents of harassment following the whistle-blowing report. The Inquiry has received copies of notes of the investigatory interviews conducted by the external investigating officer. These appear to corroborate the whistle-blower's allegation that staff had been instructed to lie about four-hour waiting times in order to avoid breaches. The notes also reveal that the investigating officer was told that patients were moved to the clinical decision unit *"on paper but not in reality"* in order to avoid breaches of the target. The whistle-blower's interview notes reveal that she reported to the investigator an incident that had occurred in 2006 where one of her patient's records had been altered in order to disguise a breach of the four-hour waiting target; she had been threatened with disciplinary action for this, despite the fact that the management were aware that the record had not in fact been altered by her but by one of the ward sisters. She repeated this allegation in her oral evidence to the Inquiry. Although the Trust has been asked for a copy of the investigator's report on these matters it has not been provided, and the Inquiry has no information on that report's conclusions other than a draft letter informing the nurses that they were subject to the first stage of the disciplinary process.

183. The whistle-blower gave evidence to me of the hostile behaviour towards her of staff close to those who had been the subject of her complaint. It appears from internal Trust documentation seen by the Inquiry that it was believed that witnesses were afraid to come forward. The whistle-blower told me, however, that not all staff had been hostile to her, and she commended the support she had received from, in particular, the matron, another nurse and a junior doctor.

184. The two members of staff who were subject to the complaint were reinstated to work in A&E and returned to work there with no explanation being given to the whistle-blower, who had waived any right to confidentiality as part of the whistle-blowing process. Her experience of the process, she told me, was a principal reason why she then left the employment of the hospital:

I stuck my neck on the line and I went through an awful time, physically frightened, as did a few other members of staff. The investigation was handled as it was, we weren't given any real explanation or anything or debrief following it. We were just left to flounder, left to then work alongside and under these sisters who, you know, nothing major happened but there was always a feeling of, you know, it could, they could really turn on you or something could happen. So I did think: I can't work like this any more. This is just ridiculous.

Comments

185. It is always difficult and challenging for an investigator to decide between two conflicting accounts in relation to a serious allegation. It is even more difficult to assess after the event, and largely from documentary material, whether the conclusion was justifiable. On the face of it, however, the conclusions on the serious allegation that a member of staff was invited to or encouraged to fabricate a record were generous. The report does not explain why the evidence from witnesses other than the principal whistle-blower of what amounts to a culture of accepting fabrication did not lead to a more critical conclusion. Even if it were accepted that the remark had not been intended seriously, it was accepted that it had been taken seriously, and yet no action was recommended against a senior sister who should have known better.

186. An inadequate degree of protection was given to the whistle-blower. Heightened tension and interpersonal difficulties are almost inevitable in these circumstances, and yet the impression is that the subsequent complaints of harassment were not taken as seriously as they should have been. Very firm action may be required to nip such behaviour in the bud, and there is no evidence that this happened.

187. Of perhaps even more concern is that clear and cogent evidence that record fabrication was habitual did not lead to a general investigation and audit of records. The Chief Operating Officer, when asked about this episode, said that she did not regard it as a whistle-blowing matter:

Q: *But essentially what you had here was a whistle blower, didn't you?*

A: *I am not sure that at the time it was raised as a whistle blowing incident.*

Q: *Whether it was raised as a whistle blowing incident or not, that's what it was, isn't it? And as a senior manager within the organisation, oughtn't you to have recognised it as such?*

A: *I am sorry, I didn't recognise it as such*

188. She could not recollect the outcome:

I think they certainly both had some development issues that were raised from it, some learning issues and some support they both had...

189. She agreed that she must not have regarded the matter as very important:

Q: *It sounds to me, is this fair, that at the time you couldn't have ascribed much importance to it?*

A: *Yes, I was aware of it, and yes, I knew it was being investigated, but it isn't something that has stuck in my mind as being a very important issue. That is fair to say...*

190. She also dissociated herself to an extent from concerns about the protection afforded to the whistle-blower:

I didn't think it was a problem at the time, and I do not believe that the individual wasn't supported through the transition of the staff going back into the place, but I don't know.

191. She denied that the two sisters complained against had been brought back to A&E because they were effective in ensuring compliance with the A&E target. However, this was challenged by the modern matron, who told the Inquiry that the two nurses were returned to the department because the four-hour target was suffering. She also told the Inquiry that she had no idea what the outcome of the investigation was but that she considered it to be *"absolutely appalling"* and *"disgusting"* that these two nurses were brought back.

192. Another aspect of concern arising out of this episode is that a serious matter impinging on a target the Board set so much store by was not discussed at their meetings. This was in spite of A&E performance generally and target compliance in particular appearing frequently in the minutes.

Overall comments

193. A study of the experiences of those involved in these three episodes arising out of raising serious concerns is not encouraging. It must not be forgotten what pressures can be applied to deter staff from coming forward, and how little it can take to dissuade nervous individuals from pursuing matters. Any failure to go the extra mile to protect and respect those who raise genuine concerns has to be seen against a national background, in which there are frequent reports of injustices being perpetrated against whistle-blowers. How many such reports are correct is not in point: staff locally will see in every failure to take the appropriate and expected steps internally as reinforcement of what they read happening elsewhere.

PATIENT STORY

I heard from a very lively 90-year-old woman who was admitted to Stafford Hospital for 10 days in 2008. She was in good health and had even undertaken a parachute jump on her 90th birthday in order to raise money for soldiers returning home from conflict. During her working life she had practised as a qualified nurse for about 20 years, while raising her two sons.

In February 2008, her GP referred her to Stafford Hospital because she had developed an acute urine infection and was experiencing severe abdominal pain. She arrived at A&E, where she was alarmed to see a single doctor attempting to cope with the waiting queue, and remained there for four and a half hours. During this time, her son and daughter-in-law were not allowed to see her, which caused them great distress. She was then transferred to the emergency assessment unit, which in contrast she felt was professional and caring.

On the fourth day, she was moved to Ward 10 where she was told that she would be seen by a urologist. The ward was extremely cold and when she alerted nursing staff, she was told either to sleep in her dressing gown or to place it over her bedcover. For the first three days on Ward 10 she was not seen by a doctor, let alone a urologist. Ward staff were also unable to tell her the name of the person she was waiting to see.

She told me that, due to being partially sighted and having difficulties with her eyes, she had used eye drops for 17 years. However, while in Stafford Hospital she was not allowed to administer them herself. Instead, she was woken every night after 10pm in order for a nurse to give them to her, which she considered a waste of nursing time.

She described a *"terrible"* incident that occurred one day when she went use the shower on the ward. *"... I stripped and hung my clean nightie and dressing gowns and my slippers were all over there. I walked across this very large room, and for me everything is semi-dark, and it wasn't a well-lit room, and there was a bar and I was already attached to a catheter, so I put the catheter hook on there, on this bar. And then I turned the water on, and to my horror, the head of it must have been on the chair, and it whizzed round the room at a terrific speed with the power of the water, hitting all my clothes that I had hung up, hitting me in cold water. Of course, I couldn't see it, it was going round so fast. I was absolutely soaked. So were all my clothes. The floor was like a swimming pool. I was yelling but nobody came and in the end I managed to catch it and turn it off and go dripping off down to the ward. And I passed a nurse and she said: you are wet. I said: I am absolutely soaked. But nobody did anything and one of the patients got out of bed and helped me get a dry towel and hang my dressing gown up and stuff my slippers with paper. It was just a farce. But what if I had been frail and fallen down?"*

She remembered one occasion when a patient next to her fell out of bed at 12.45am. Another patient rang the bell for assistance, but after 10 minutes nobody had arrived, so this patient went to look for a nurse. The nurse looked at the fallen patient and said, *"What are you doing down there? Now...get yourself up, my mate is eight months pregnant and she is not allowed to lift."*

This lady told me of her great concern for other patients on the ward. She said, *"So many old people lying dependent on too few staff was for me frightening. For them, many of whom were deaf, partially blind or crippled, they must have felt that they had been completely abandoned. I cannot believe that supposedly fully trained nurses with vocation, care and compassion gain any satisfaction from such an abysmal situation."*

She also felt that the attitude of nursing staff on Ward 10 was poor. Nursing staff continually called her by her Christian name, completely disregarding her frequent requests to be referred to by her full name. This made her angry and she thought it was unprofessional.

Despite not having been reviewed by a urologist, she felt that her condition had improved and requested to be discharged. Her son drove 50 miles to take her home, but on arrival he was told that she had already left hospital when she was actually only a few feet away in the patients' lounge. He then drove to her house to discover that she was still in the hospital.

After her experience, she met with the Chief Executive to discuss her complaint. She was so concerned with other patients that she volunteered to visit the wards to help feed them. She was told, however, that this was not possible because health and safety regulations would not permit it.

She concluded her written evidence to me with the following stark summary: "*malnutrition and starvation...was one of the hazards of being in a geriatric wards at Stafford.*"

Section F
The Board

Introduction

1. In the course of the previous sections, the position of the Board has been analysed in relation to many of the themes this Inquiry has looked at. In this section, the role of the Board and its individual directors will be considered more broadly. It will focus on the evidence obtained by the Inquiry from the directors and while looking at what they have said about some of the themes and concerns already discussed, it will not be necessary to examine here what all of them have said about every issue. In particular, the chapter will consider:

    - the background and appointment of directors;
    - the Board's perception of the issues facing the Trust;
    - the role of the Board in the Trust;
    - the application for FT status;
    - the interface between the Board and the public; and
    - the process of changing the leadership in 2009.

2. The Inquiry was assisted by evidence from all the directors it contacted with the exception of Mr Yeates, for the reasons explained in the Introduction, and Mr Denny who was unable to attend for personal reasons. I am satisfied that they have all done their best to assist the Inquiry even though, as will become apparent, I have been unable to agree with all the views they have expressed. In the case of Mr Yeates, although he has not given direct evidence I have had access to a number of documents, including his response to the report that the Trust commissioned from Peter Garland, a retired Department of Health official, to determine whether there was a prima facie case for taking disciplinary proceedings against him. The Inquiry has also been assisted by the solicitor who had been instructed by Mr Yeates in relation to the termination of his employment with his perspective.

3. This section will focus on points raised by directors that give an insight into the thinking and approach of the Board, rather than attempt to present a detailed analysis of each issue that has been considered in this Report.

Chronology of Board membership

4. During the period with which the Inquiry is concerned the Board non-executive membership was as follows:

Name	Appointed	Ended
Joan Fox (Non-Executive)	1999	October 2006 (completed term of office)
Gerry Hindley (Vice Chair)	April 2000 (January to July 2006 seconded to North Staffordshire Trust)	January 2009 (completed term of office)
David Denny (Non-Executive)	October 2000	February 2009 (completed term of office)
Toni Brisby (Chair)	October 2004	March 2009 (resigned)
Peter Bell (Non-Executive)	November 2005	March 2009 (resigned)
Mike Wall (Non-Executive)	November 2005	March 2009 (resigned)
Roger Carder (Non-Executive)	April 2007	In post
Sir Stephen Moss (Non-Executive)	February 2009	Chair since July 2009
Dennis Heywood (Non-Executive)	February 2009	In post
David Stone (Interim Chair)	March 2009	July 2009

5. The Executive directors, grouped by post, were as follows:

Post	Name	Appointed	Ended
Chief Executive	David O'Neill	1998	June 2005
(Acting CEO)	John Newsham	June 2005	August 2005
	Martin Yeates	September 2005 (interim) December 2005	March 2009
Chief Operating Officer	Karen Morrey	May 2006	September 2009
Finance Director and Deputy CEO	John Newsham	1992 (Deputy CEO pre 1998)	June 2008
	Michael Gill	July 2008	–
Medical Director	Dr John Gibson	2003	March 2006
	Dr Val Suarez	September 2006	March 2009
	Dr Manjit Obhrai	April 2009	–
Director of Nursing and Quality	Jan Harry	February 1998	2002
Director of Clinical Standards and Chief Nurse	Jan Harry	2002 (Chief Nurse in 2006)	July 2006
Director of Nursing and Governance	Helen Moss	December 2006	October 2009
Director of Human Resources	Norma Sadler	May 2000	July 2006

The experience of the non-executive directors

6. The Chair: Ms Brisby's background experience included membership of a Community Health Council and a Non-Executive directorship of a mental health NHS Trust. She had been a complaints convenor. She had no experience of acute hospital trusts other than as a patient and a visitor. She was confident she possessed the appropriate skills to take on the Chair's role:

I felt as though I had got some skills in terms of understanding how organisations functioned and particularly how groups of people within organisations functioned.

7. She pointed out that the selection process was conducted by the Appointments Commission who would be able to determine if a candidate was not appointable or that his/her skills or other attributes were not suitable for the post.

8. Of the other non-executive directors:

   - Dr Wall was a former director of public health;
   - two were accountants: Mr Carder was a tax specialist and a director of an accountancy firm and Mr Bell came from industry;
   - Mr Hindley was a contracts manager;
   - Mr Denny was a public sector senior manager; and
   - Sir Stephen Moss had a background in health service management and nursing

9. Mr Carder (who remains a non-executive director) told me he got a feel for the organisation by having a programme of visiting each of the executive directors over his first few months and finding out what they did. He had himself never visited the wards as director, principally because he has mobility difficulties. He was aware that his colleagues had done so.

Comments

10. Sir Stephen Moss, offering observations about his predecessors said:

    I think that is a fact of life for a hospital the size of Stafford, because it will inevitably attract people into their first director's jobs, but I think the problem at Stafford was that the board, in recognising that that was a fact of life, hadn't actually done anything about doing something about it, if you like. In terms of the board's development, that immaturity didn't seem to feature in the way that they thought about development.

11. It is worth noting that only Ms Brisby had previous experience as a non-executive director of an NHS trust (apart from Sir Stephen who arrived only at the very end of the period), and none had previously been associated with an acute hospital. The majority had no previous NHS experience, other than as patients. I understand that this sort of experience profile is not unusual among boards managing district hospitals like Stafford. While this may be so, it inevitably makes the non-executives as a group much more dependent on the advice of executive directors and less well equipped to mount an effective challenge on technical issues.

The standards expected of directors

12. The Appointments Commission makes appointments of non-executive directors to positions on NHS trust boards in partnership with the Trust, and is available to assist foundation trust governors in making similar appointments. Executive directors are appointed to both types of trust by their boards.

13. Directors whether executive or non-executive are not short of guidance as to what the post entails. *Governing the NHS* was published in 2003[61]. This set out the roles of the Chair, non-executive directors and Chief Executive. This guidance is being reviewed and a revised edition is expected to be published in February 2010.

14. This guide provides a useful reminder of the respective duties of executive and non-executive directors and of the collective role of the Board. It is pertinent to pick up a few points from it.

15. Directors were left in no doubt about the importance of the Board leading and taking responsibility for clinical governance, and engaging with the public.

    Within the NHS following the Bristol Inquiry, the Alder Hey Inquiry and others, serious questions were being asked about the quality of clinical care. It was realised that responsibility for quality extended beyond the clinicians concerned and was in reality a multi-facetted responsibility that could only be shouldered in its entirety by the Board. This quality management responsibility was encapsulated for the NHS in a system of Clinical Governance.[62]

    The message that runs through the entire guide is that, whatever the type of Board, the interests of patients are best served by a strong system of governance. Through good governance, the Board can enhance the care and wellbeing of patients and those staff who look after them. Conversely, in an organisation which is not properly governed and which is out of control, staff time is wasted in fire-fighting with inadequate plans and resources, with the effect that the care given to patients and their families inevitably suffers.[63]

    It is the duty of the Board to ensure through Clinical Governance that the quality and safety of patient care is not pushed from the agenda by immediate operational issues.[64]

[61] Department of Health (June 2003) *Governing the NHS – A Guide for NHS Boards*
[62] Ibid., p. 5
[63] Ibid., p. 6
[64] Ibid., p. 11

The need for public accountability puts a special obligation on NHS Boards to conduct themselves and their business in an open and transparent way that commands public confidence. For that reason, Board meetings are open to the public and should operate in a way that makes their business understandable to the public... It follows from this commitment to open debate that the use of the confidential part of the Board meeting should be restricted to those areas generally concerning named individuals or commercially sensitive information, where there is an overriding need for confidentiality.[65]

16. This commitment to openness is reinforced by the *Code of Conduct for NHS Boards*:

    NHS Organisations should forge an open and positive relationship with the local community.[66]

17. The respective roles of the Chair and the Chief Executive are summarised thus:

    Whilst the Chair leads the Board, the Chief Executive leads the executive team and takes responsibility for their achievements. A strong relationship between the Chief Executive and the Chair is therefore essential to the performance of the Board and the organisation. The Chair needs to be a source of support for the Chief Executive, both in their personal development and in the development of the organisation. At the same time, the relationship must accommodate constructive debate and challenge and should not become a 'cosy' partnership that becomes impossible for nonexecutives to question.[67]

18. There was emphasis on the need to take an overview rather than to become enmeshed in detail:

    Non-executives will also need regular updates on the results and outcomes of their strategies to keep them abreast of the organisation's performance. It is for the Chair to ensure that this information is timely and sufficiently comprehensive, but without including unnecessary operational detail that the Board does not need and which would only serve to waste the time of directors.[68]

[65] Ibid., p. 14
[66] *Code of Conduct for NHS Boards*, Appointments Commission/DoH (July 2004) p. 3
[67] *Governing the NHS* p. 16
[68] Ibid., p. 17

19. Non-executive directors were discouraged from concerning themselves with operational detail:

Sometimes there can be a narrow dividing line between strategy and operational management and non-executives need to be careful not to be drawn across this boundary. To do so risks them becoming distracted by the operational detail and thereby unable to maintain the distance and objectivity needed for their role in scrutinising performance.[69]

... they should not need to spend time in policy committees or shadowing executive directors simply to "find out what's going on".[70]

20. Nevertheless, exposure to operational matters was encouraged by the suggestion that non-executive directors should sit on the Audit, Clinical Governance and Risk Management Committees of the Trust.[71]

21. At the same time, their attention was drawn to the importance of safety:

It is also a key responsibility for non-executives to be aware of their obligations around staff and patient safety and the duty of the Board regarding adverse incidents and occurrences.[72]

22. Also stressed was their role as representatives of the local community:

Non-executives are drawn from the local community and therefore have a particular duty to it. Clearly, the small number of non-executives on a Board cannot represent the spectrum of patient and public experience and they should not attempt to substitute for focus groups or represent single issue interests. However, non-executives can ensure that the interests of patients and the community remain at the heart of the Board's discussions.[73]

23. The overall tenor of the guidance emphasises that the Chief Executive has operational responsibility for delivering the performance required to achieve the Board's strategy. It may be thought that, in the events under scrutiny in the Inquiry, it is this Board's method of observing these requirements that goes some way to explaining the disconnection between what was being discussed and worried about at Board level and what was concerning patients and their families at the front line.

[69] Ibid., p. 23
[70] Ibid., p. 27
[71] Ibid., p. 37–39
[72] Ibid., p. 24
[73] Ibid., p. 24

24. Monitor also published *The NHS Foundation Trust Code of Governance* in 2006.[74] This covers many of the same areas but emphasises the Board's responsibilities:

... NHS foundation trust directors are ultimately and collectively responsible for all aspects of the performance of the foundation trust [and therefore] need to be able to provide more focused strategic leadership and more effective scrutiny of the trust's operations.[75]

25. It is also clear that along with this responsibility comes collective accountability:

All directors have joint responsibility for every decision of the board of directors regardless of their individual skills and status... [They] have responsibility to constructively challenge the decisions of the board and help develop proposals on strategy.

As part of their role as members of a unitary board, non-executive directors have a particular duty to ensure such challenge is made. Non-executive directors should scrutinise the performance of the management in meeting agreed goals and objectives and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management are robust and defensible.[76] *... Where directors have concerns, which cannot be resolved, about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.*[77]

26. This description of the Board's own accountability might be thought to be similar to that which would be expected of any NHS Trust.

27. There is also a *Code of Conduct for NHS Managers*[78] which sets out a list of obligations. The NHS manager is required to *"observe the following principles"*:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;

[74] Monitor (2006) *The NHS Foundation Trust Code of Governance*
[75] Ibid., p. 3
[76] Ibid., p. 7
[77] Ibid., p. 9
[78] Department of Health (October 2002) *Code of Conduct for NHS Managers*

- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development.

28. The managers to whom this code is addressed include the Chief Executive and other executive directors; the code is required to be incorporated into their contracts of employment.

Comments

29. This structure of guidance about conduct and standards is doubtless useful but it is questionable whether it quite measures up to the sort of guidance that doctors and nurses have to comply with in order to maintain their registration. Given the importance of the role of senior managers and directors in a hospital trust, whether or not a foundation trust, the standards to be expected of managers should be similar. The Code of Conduct is short of specifics and does not emphasise the duty to patients. All the guidance emphasises the distinction between strategic and operational matters, but it may be thought, when some of the evidence set out below is considered, that there is a danger of some directors excusing themselves from a detailed knowledge of the issues facing their trust on the grounds that they are operational. The correct position, surely, is that any matter which has a serious impact on patient safety and the quality of care is a matter justifying the interest and attention of directors, whether executive or non-executive.

The Board's understanding of its role

30. The directors, both executive and non-executive appeared to have a general understanding of their roles (both individual and collective) and the boundaries between them, which echoed the principles in the guidance.

31. Ms Brisby expressed her understanding in this way:

I saw the chair's role as to run the Board and make sure that the Board was properly equipped to do its task, which I will come back to in a second and the Chief Executive and the other executive roles run the organisation. The Board's role, I thought, was to make the right appointments, be clear about the strategic direction and then check to make sure that the things that should be happening to achieve a strategic direction were actually happening.

32. She accepted that the strategic purpose of what was done was the care of patients and that financial management was a means to that end:

Q: *Presumably the strategic direction of any hospital must include the achieving of the fundamental aim of the hospital, which is to provide good quality care.*

A: *Yes, to look after people properly, absolutely.*

Q: *So you encompass that within the expression "strategic direction"?*

A: *Yes completely.*

Q: *But also especially encompass within that how you achieve that goal presumably or the means by which you achieve that goal.*

MS BRISBY: Yes but I – you have the high-level strategic objectives – and then there is a layer below that which is a means of achieving the strategic objectives, which I would argue the finance function is one of those. I had a big debate with people about whether breaking even financially should be in the strategic objectives and I think I won because it fairly clearly shouldn't. It is the means for achieving them.

33. Mr Carder said he was aware of the requirements of the Code of Conduct and the guidance. He had been given an information pack on joining the Board, which had this sort of information in it. He had also been on a course for non-executives which confirmed to him the limitations of the role.

It was very much putting forward the view: the role is two and a half days a month; you should not be interfering with the executive and getting involved in running the hospital. You should read the board papers and make challenge at the board.

34. Mr Hindley told me that non-executive directors were meant to be champions of the public on the Board; he and his colleagues all lived in the area and their families used the hospital. They would have raised concerns about the standard of care if they had noted any. He told me he had found it particularly useful being able to walk around the hospital as part of a regular programme, when they were very free to talk to staff and patients.

35. Mr Bell confirmed that they took the role of being community representatives very seriously. As with other non-executive directors he pointed out more than once that to a large extent that they had to rely on the executive directors for advice, and that they did not have much time in which to familiarise themselves with detail, which they thought would have been inappropriate in any event:

You find different ways of doing things, don't you? At the end of the day, you have to rely on the specialists in these areas to assure you that by doing things in different ways, you can maintain the same standards, and as non-executives we had an extremely heavy workload and we could not be expected to get involved in too much detail and we did rely greatly really on assurances that we got, and there was challenge that went on about those very things. I mean, whether or not they are minuted or not is another question but I think that those assurances did in fact come.

Comment

36. As indicated earlier in this section, it might be thought that directors were encouraged to avoid concerning themselves with what was regarded as operational detail. While in principle that is probably correct it is the interpretation of that dividing line which is important. There should be no rigidity preventing a director from inquiring into something of concern, merely because it might be regarded as operational, and an executive should not be discouraged from reporting something of concern for the same reason, particularly if the issue raises questions of patient safety or the quality of care. There will surely be many instances in which a non clinically qualified director can only be led to understand the issues by being informed of some operational detail.

The Chair

37. Ms Brisby held the Chair throughout the time under review. It is important to emphasise that the post is a part-time one. The formal time commitment to attend to her duties as Chair was between three and three and a half days a week.

38. Ms Brisby told the Inquiry that she did visit areas of the hospital but was wary of being seen to interfere:

    I was very conscious of the need to keep a clear demarcation between the role of the executives and the non-executives, I was wary of actually going into areas where I might be seen to be interfering. What I did was to make sure that every time somebody came into hospital whom I knew I went to visit them and that actually happened quite a lot because people tended to let me know. So I was on the wards in the way that anyone else would be on the wards quite frequently.

39. She said that Dr Moss, the Director of Nursing, had clinical time on a regular basis and that during that she would be joined by non-executive directors going round wards. There were also organised visits by non-executive directors to wards about once a month.

40. Her own view of herself was that:

I was pretty visible around the hospital and I tended to know what was going on quite a lot of the time, clearly not all of the time.

41. Ms Brisby was highly regarded by her fellow non-executive directors. Mr Hindley told me, with no dissent from his colleagues present at the same hearing:

I served under four chairmen. I can say that Toni Brisby, compared to the others, is outstanding.

42. This was a particularly powerful endorsement, coming from a witness who had been shortlisted for the post of Chair in competition with Ms Brisby.

Comments

43. There is no doubt that Ms Brisby was a strong leader with a clear vision of where she wanted to take the Trust. She was capable of taking decisive action.

Medical directors

Dr Gibson

44. Dr Gibson was a consultant physician at the hospital who had been chair of the medical division, a clinical director of medicine and associate medical director before being appointed as part-time Medical Director in 2003 until his retirement in March 2006. Only one-third of his time was officially devoted to his duties as Medical Director, although he thought it took more of his time than that. He found difficulty in describing what his role had been as he obviously thought it lacked clarity:

I was a medical opinion on the Board and I gave advice on medical matters. I did not have any specific roles. I think that has now changed. During my time, as I have said in my statement, I was tasked with trying to sort out the European Working Time Directive. So I was intimately involved in that. But otherwise that was my role. I was a medical voice on the Trust Board and I gave medical advice to the Trust Board as and when needed. I also was the bridge between the consultant body, or hoped I was, and the Trust Board and fed back to the consultant body about matters arising to try to keep them in the picture, whatever is said about the gap between consultants.

45. Dr Gibson's account of the difficulties of the consultant staff committee has been described elsewhere. He did not walk round the wards in his capacity as Medical Director as much as he felt, in retrospect, he should have done. It may be significant that he did not suggest he had a leadership role.

Dr Suarez

46. It has already been noted previously in this report that Dr Suarez, a consultant histopathologist was a reluctant recruit to the post. She turned down one approach before eventually being prevailed upon to apply for the post in the absence of any other volunteer. One non-executive director had been told that she had been *"kind of almost bullied"* into taking the post. She also maintained her clinical practice while in the post. That she was unhappy in the post was confirmed by evidence that she had made it clear that she wanted to resign but that there had been great difficulty in recruiting a replacement, until the present Medical Director, Dr Obhrai was found.

47. Although she had been told she could expect to spend only 80% of her time on directors' duties, in practice she found it was closer to 100%. This led her to feel she was not doing either side of her job adequately to her satisfaction.

Comments

48. There is no doubt that the post of Medical Director has been problematic in the Trust through no fault of its recent incumbents. Each appeared reluctant to have the job and each may have felt there were difficulties arising out of their continuing clinical role. They were not enabled to act as leaders. As spokespersons for the medical staff, they may well have been handicapped by the lack of engagement of the staff generally in managerial issues and they both lacked the advantage of an external perspective before taking on this important role. Their role as advisers on medical issues to the Board may have been compromised by these factors and by their lack of involvement in some issues that were regarded as nursing rather than medical.

Directors of Nursing

Mrs Jan Harry

49. The issues between Mrs Harry and others with regard to her responsibilities for nursing matters has been canvassed elsewhere and need not be repeated. At the beginning of the period of review of this Inquiry she was established in post. Her management style has also been considered in the culture section above. She sought to distance herself from anything other than strategic concerns. For example when asked about ensuring the privacy and dignity of patients on a day-to-day basis she told me:

I can set the strategy. On a day-to-day basis, it is really up to the lead nurses in the organisation within their clinical areas to set the tone. So from my point of view I would strategically say these are the sorts of areas I am concerned about and, you know, we need to cascade it and we used to have... regular induction programmes and we had... development programmes which all the senior nurses actually went through. In actual fact some of them went through two different – very similar programmes and privacy and dignity was actually part of that. It is a cultural thing. It is not a tick box. I think what we tried to do was embed the notion of privacy and dignity as part of the function of the interaction between the nursing staff and other staff who had patient information and the nurses and the patients themselves... I did see it as my function to set the tone, but I didn't work individually with individual nurses. It was how privacy and dignity was seen as a priority within the organisation, and through that how I worked with my team and how I interacted with the directorate and the directorate teams.

50. Shortly after the critical Commission for Health Improvement (CHI) report in 2002 an action plan was formulated in which Mrs Harry was identified as the lead person responsible in a number of areas, including the maintenance of privacy and dignity, The action taken was in part the 'rolling out' of the *Essence of Care* programme.

51. She was also identified as the lead person for formulating a strategic response to clinical risk management. She told me that much training was commenced on incident reporting and attempts to instil a 'no-blame' culture. She was the lead person for developing the complaints system and this is considered below.

Dr Moss

52. This was the first post Dr Moss had held at directorate level although she had on occasion deputised for her superior in her previous post in Birmingham. She was given no training for the role, although the Board did have development sessions. She agreed that her role on the Board was to take a full part in the decision making of the organisation and that the Board looked to her for advice on nursing matters.

Comments

53. It will have been clear from other sections of this report that Mrs Harry did not appear popular with many witnesses. She did not attract the confidence of Ms Brisby who engineered her departure. There is, however, no doubt that she had a forceful management style and was determined to make improvements, as she saw them, to the Trust. She was effectively the only source of advice to the Board on nursing issues, and yet there was, at best, uncertainty about the responsibility for nursing matters. However experienced, conscientious and well intentioned she was, the Board was allowing itself to be vulnerable in accepting a sole conduit of nursing opinion from one Executive Director.

54. Dr Moss may have started in the role at a disadvantage in not having had sufficient experience of senior management in this sort of trust. There is an impression that she came from an organisation where there had been few challenges to one where there were many, without realising in advance what the job would demand. However, she demonstrated to the satisfaction of the Inquiry that she was conscientious and quite able to work out what needed to be done about deficiencies once these were raised.

Director of Operations

55. The differences of perception between the Director of Operations and the Director of Nursing have already been considered. It will be seen that the non-executive directors placed great emphasis on operational matters being left to executive directors. Accordingly, it is not surprising that at least some of them lay responsibility at the door of the Chief Operating Officer, Ms Morrey. She on the other hand regarded issues about risk assessment in relation to nursing staff to be largely a matter for the Director of Nursing. Despite having management responsibility for the nursing establishment, she did not feel she had the expertise to comment on whether it was appropriate, for example, for one senior sister to be responsible for 78 beds on the medical floor.

Q: *Did that strike you as a reasonable and proper arrangement?*

A: *... I do not think I am able to answer that question, sorry...I am not a clinician and I do not have the clinical expertise to give you a right or wrong answer to that one.*

56. Her focus seems to have been on the delivery of targets:

I got the managerial responsibility for the nursing staff but not for their clinical standards, if that makes sense.

Q: *Right. What sort of proportion of your time would you say was taken up with dealing with targets and ensuring, so far as you were able to, that they were met; is that an important central part of your work?*

A: *Yes, that was one of the key objectives of my role around delivery of the access targets. So A&E, waiting times, they were the biggest issues.*

Comments

57. The observations quoted above are examples of something that is of concern about the role of Director of Operations, as she perceived it. She gave the Inquiry the distinct impression that she focused on working with specific issues, such as targets, rather than taking a broad overview of the work of the organisation. While this may be inevitable to some extent in this role, this may have contributed to, for example, the development of an unquestioning target culture.

Directors' overview of issues

Ms Brisby

58. On her appointment, Ms Brisby predicted that the task presented by the Trust would be a daunting one:

    People warned me it was a difficult one. All sorts of expressions were used about it which I think were designed to put anyone off.

59. She acquired some perspective on the issues that might arise because a relative happened to be treated as an inpatient shortly before she took up the post, was very dissatisfied with the experience and made a complaint, the outcome of which had left them disappointed. Bad nursing care on Ward 1 had formed part of the complaint:

    She felt that the nursing care was chaotic, that drug rounds didn't happen on time and she wasn't given proper information.

60. Ms Brisby distanced herself from the complaint and its management in view of her position.

61. Further information about the Trust came from the strategic health authority (SHA) from whom she received a briefing. She was informed by its then Chair, Mr Brererton that this was a *"failing"* trust. Similar informal views were expressed by colleagues in the area. She told me:

    there was quite a lot of information saying this is a bit of a disaster area.

62. Ms Brisby informed the Inquiry that, from the information she had received from the SHA and others were, she understood the problems facing the Trust as including:

- very poor relationships with outside organisations;
- a Byzantine committee structure;
- no identifiable measures of clinical quality;
- lack of training and development for staff and old fashioned practices among doctors and nurses;
- lack of supervision/appraisal;
- finances that seemed spiralling out of control – *"a potential financial black hole"*;
- lack of leadership at the most senior level; and
- poor relationships among consultants.

63. She was aware that the CHI rating for the Trust had fallen from three to zero stars. As already noted in the Governance section, she was unaware of the critical CHI report of 2002.

64. Ms Brisby told the Inquiry that, while the SHA briefing had been clear, it did not mention nursing numbers as an issue. She presumed that it was because:

This was seen as operational.

65. On taking up the post, she formed the view that the Board was not functioning effectively and that the then Chief Executive did not enjoy its confidence. She set about arranging for his replacement with Mr Yeates.

Other non-executive directors

66. On Ms Brisby's appointment, she convened an early meeting of non-executive directors. Mr Denny told me, and other non-executive directors present confirmed this, that it was unanimously agreed that:

improvements were not happening as we had wished or been led to expect, and we resolved that critical action was required, beginning with the replacement of the Chief Executive Officer.

67. Mr Hindley told me that:

The organisation left an awful lot to be desired. That we didn't think and had thought for a long time that the then Chief Executive wasn't up to the job... I used the phrase at the time, I think the hospital runs in spite of the Chief Executive rather than as a result of decisions taken by the Chief Executive.

68. He said he had raised such concern with a series of previous chairs but Ms Brisby was the first to take action on them. His concerns at the time were principally in relation to the finances of the organisation but also the ineffectiveness of the Chief Executive. He did not have any particular concerns about the standard of care.

69. This was echoed by Mr Bell. Through his community contacts he heard of low-evel criticism such as that the wards were somewhat noisy and that there was a slight delay being treated in the accident and emergency department (A&E):

But never before the HCC investigation did I have any cause whatsoever to feel that there were any concerns that ought to be brought to the Trust's attention.

70. Dr Wall agreed adding that in the course of running his domiciliary care agency he had to visit the hospital and others in the region with clients and came to the conclusion that the hospital was:

a pretty average hospital in terms of health care.

71. Mr Carder, who arrived after the departure of the previous executive team, was aware that there had been a wholesale change in the executive team. When asked whether he had any understanding what the reasons for this had been he told me:

I mean, I was told that the old Chief Executive was very good at sweeping things under the carpet and kind of hiding the problems.

Q: *That would suggest to me that there were therefore problems to be addressed.*

A: *Yes. But the impression I got was they were being addressed by the new team.*

Q: *But did you have available to you, whether formally or informally, a list of what those problems were?*

A: *No.*

72. Because of the limitations on the non-executive role described above, he felt he was very much reliant on what the executives were telling the Board, which could only be checked over a period of time by examination of complaints and concerns from other organisations such as the primary care trust (PCT) or SHA, or from a protest group. That type of challenge, he said, could only come over a period of time:

I think I was asked at the original inquiry where I gave evidence there: how did you know you were being told the truth? The answer is you don't know you were not being told the truth, and the only way you can find that out is to review things over a period of time and challenge it – eventually if you are not being told the truth, inconsistencies appear and it is challenging those inconsistencies. But in a relatively short period of time, you can't necessarily pick that up.

73. He told me that until Cure the NHS and its members had come forward and described cases at the governors' meeting, he had not realised how bad things were:

So the point there is that it took an organisation of very unhappy patients and family members of patients to gather themselves together, have the wherewithal to do that, to draw to the attention of the hospital that which it ought to have known for itself.

A: *That is a fair point. Certainly it was a window on to what was going on. Previously as a non-executive, I had absolutely no idea what was happening.*

Q: *Of course it also follows that had they not done that, presumably the Board would have continued in ignorance.*

A: *Potentially.*

74. As a result:

Cure the NHS was a heck of a shock.

75. When she started as Medical Director, Dr Suarez was aware that there were problems but, as can be seen from some of the quotations from her evidence elsewhere in this section, she was not particularly aware of ongoing serious concerns requiring urgent action.

76. Dr Moss was critical of what she found when she arrived:

I was quite surprised with what I found within nursing when I arrived at the organisation. Particularly, I think, around levels of accountability for the nursing staff and also the nursing workforce was quite a stagnant nursing workforce, it hadn't seen great deals of change over time, which I think has impacted on the way that nursing was practised... I think people didn't move around and they didn't gain experience from other organisations, and practice didn't probably progress as quickly as it might have done, because there wasn't experience from elsewhere that was brought into the organisation.

77. She considered that the governance arrangements were weak and she had concerns about the nursing establishment and skills mix, which she thought was not right across the organisation.

78. She certainly found there were more problems at the Trust than she had been expecting:

Q: *Did the job turn out to be what you were expecting or not?*

A: *No. No. No.*

Q: *And again obvious to you but why not?*

A: *I think the level of repair work that needed to be done was far more than I anticipated.*

Comments

79. What is striking about much of the evidence I heard from directors, particularly non-executive directors, is that there was a considerable appreciation that this was a trust with serious problems at the time they started. Action was demanded on occasion to confront issues, but it may be thought that too often the initiation of a process, for example, the replacement of the Chief Executive or the setting up of a new governance committee structure, was enough, and that the hospital executive could be relied on to get on with things. A common theme has been that even where issues have been recognised, the remedial action required has not been pursued with vigour or urgency and the results of that action have not been effectively monitored. As will be demonstrated, when the formidable list of problems recognised by Ms Brisby on her arrival is compared with the trenchant observations of Mr Sumara about the position on his arrival, it is remarkable how few of them had been solved. It is to be concluded that whatever action was taken was ineffective at least in the sense of being too slow.

Complaints

80. As the lead person developing the action plan in relation to complaints, Mrs Harry was asked about her involvement in the plan. She described the system in place as *"robust"*. She told me she read all the responses before handing them to the Chief Executive for signing. Issues that were of concern were flagged up for the review committee, chaired by a non-executive director. She said she was not involved in that committee coming to an end, and she did not sit on it. Indeed, she had been unaware that the committee had stopped. She continued to read responses and action plans after Mr Yeates took over, and believed that the Trust took them seriously. She thought that the review committee followed up action plans and therefore had not done so herself. She was unable to say what follow-up took place after the committee was disbanded.

81. Ms Brisby's appreciation of the dividing line between operational and strategic issues led her to stopping them being reviewed by a complaints review committee in discussion with the Chief Executive. In her view:

actually that committee sounds like a really good idea and didn't do anything, nothing came out of it and it seemed to me that it conflicted with the role of the non-executive because the role of the non-executive is actually not to get into the detail, not to get into the operational detail and most of the complaints were about operational detail.

82. She was challenged about this view and defended her position with characteristic forthrightness:

Q: *If you really want to know what is happening on Ward 10, surely the story behind some of the more serious complaints actually tells you, in a way that a line saying there has been a decrease in complaints about staff attitude, does not?*

A: *I do not think that does at all, I think you are right. I still think there is a real risk of looking at one or two complaints and getting a view that is completely partial and biased. That was what I was concerned about. What we needed was to make sure that there was a complaints system that functioned that dealt with issues at the right sort of level and again the department guidelines.... all say this, deal with issues at the right level...*

Q: *But why is that inconsistent of informing yourself of the detail of at least some complaints? Say, for instance, you might pick up as we have seen in this Inquiry and I am sure you are now aware, we get complaints of an particular nature which are said to be addressed by an action plan and yet the same complaint is being made a year later being addressed by yet another action plan, which would suggest something wrong in the system rather than inviting you perhaps to operational interference. Isn't that a fair point?*

A: *Actually, no, I am not sure it is. I think if complaints have gone through a process and the action plan hasn't been properly actioned and then a similar complaint has come up again, that should get picked up by the high level information.... I am fairly convinced that the system we have got isn't the right one but I am also not at all convinced that had having non-executives looking at individual complaints or Boards looking at individual complaints is the right way to do it either.... I would suggest there might be a better role for the governors in relation to complaints because I think they are now in the foundation trust the group of people who are best placed.*

83. She pointed out that the Department of Health requirement for non-executive directors to have a formal role in the complaints system came to an end in 2005. Ms Brisby agreed that the categorisation of figures about complaints that came to the Board was uninformative and that the non-executive directors had expressed concern about this. However, nothing had been done about this by the time she left:

... nothing had been done. It would have been because we would have come back to it.

Q: *Yes, but how long do you need?*

A: *Well, once you have the sack it is rather difficult to do any more.*

84. In spite of this identified deficiency she said that the Board was aware, from what they were told about complaints, that there was a *"potential"* problem in A&E during its refurbishment, and that complaints about Wards 10, 11 and 12 were highlighting staffing issues, at least towards the end of her period in office. Until then the Board had not been aware of staffing issues; they did not know about staffing levels on individual wards. On reviewing Board papers, Ms Brisby felt that the annual governance reports did not highlight particular areas of concern as to staffing levels, and that the Board was not made aware of a high number of complaints on particular wards. There had been a general increase in complaints but this was consistent with national trends. While she emphasised that the task of tackling the root causes of complaints was a serious one, she thought that:

Individual complaints are primarily an operational issue for the Trust's senior managers to address and are not a function of the Board.

85. Mr Carder told me that after some time on the Board he started to ask for more detail about complaints because the information provided did not allow him to see if there were any trends. He began to ask for information about the five worst complaints, although this was probably after the encounter with Cure the NHS members at the governors meeting. He also had concerns about the quality of the response being given to complainants and encouraged more face-to-face meetings.

86. The Chief Operating Officer agreed that the reports to the Board did not deal with the substance of complaints.

Comments

87. The issue of complaints has been looked at in an earlier section of the report. As far as the Board is concerned, it appears that there had been a recognition that there were problems but that the action taken distanced the Board from the reality lying behind complaints. They received figures and superficial trends but nothing which indicated reliably the seriousness of complaints or whether they indicated systemic issues. This must have been a major reason why the Board appears to have remained unaware of many of the issues highlighted in the HCC report.

Clinical floors

88. Mrs Harry's role in this project has already been fully considered above, as have the problems associated with this project. It was already underway when Ms Brisby joined the Trust. She said that:

    The Board was kept informed about progress but rightly or wrongly did not take steps to review or intervene.

89. However, she said that the Board had clear advice from Mrs Harry and Dr Gibson, supported by a professor of nursing, that this was the way to improve nursing quality and practice.

90. Ms Brisby was asked when she became aware that this was, in her words *"a really bad idea"*. She told me:

    When it was too late to do anything about it. Actually because it was probably about 2006 that issues like MRSA and C. Diff started to surface in the national consciousness because it hadn't been an issue before then. There was really good evidence to suggest that the more people were moved in a hospital, the more they were likely to be exposed to infection. That was one chunk of stuff. Another chunk of stuff was particularly for elderly people and a lot of our patients were elderly people, shifting them around from place to place was just awful. It was really not a decent way to treat people.

91. She said that by the time these considerations had come to the fore the scheme was already in place. She pointed out that Mrs Harry's proposal to change the skills mix was considered at a Hospital Management Board meeting on 24 April 2006, and that five senior doctors had attended and not questioned it. She disagreed that Mrs Harry had had nothing to do with the skill mix changes associated with the medical floor proposal, recollecting that she was a very strong advocate of it.

92. The time when she became aware of problems coincided with the time when staff governors were appointed. They brought advantages in her view:

The staff governors were a very useful and reliable source of information. Because there tend to be two sides to most stories I am always quite wary of special pleading and individual views. Staff governors were a very trustworthy group who had an overview but also had contact with the frontline and provided information of this sort.

93. She pointed out that by the time she left, the Trust had started a process of reviewing the Trust's use of space.

94. Asked whether the perceived financial benefits had played a part in the approval of this scheme, she thought it had been a factor:

I think that's really quite likely given what I was saying earlier about the need to improve productivity. I think it is a factor. I think it is... unfortunate when finance looks as though it is driving something like this because it clearly shouldn't.

95. Risk assessments for this sort of scheme, she told the Inquiry, would have been dealt with at divisional level and would not have been seen by the Board.

96. Part of her explanation for there being no immediate reversal of the scheme once problems began to become apparent was directed at what she perceived to be NHS culture:

I think what happens in the NHS is that things change in all sorts of ways and mostly people actually manage to work within the changes. I think this may have been asking people – asking quite a lot of people and certainly in the case of the [emergency assessment unit] *I think that was asking an awful lot of people, but I think it is very usual for things to be imposed on hospitals. I am not saying this particular plan was imposed on us because it wasn't but things* [tend] *to be imposed on hospitals and the organisation simply adapts and works with it.*

97. She could not recall the changes to Wards 10, 11 and 12 (the medical floor) having been considered by the Board, and agreed that they should have been.

98. The non-executive directors were asked about the recollections of the Board meeting in January 2006 at which the surgical floors project was approved.

99. Mr Hindley, on reviewing the minutes of the Board meeting, thought that the points recorded in the minutes were just the sort of matters that Mr Yeates raised which his predecessor would not have done. He told me that before Mr Yeates' arrival there was an inadequate approach to risk management, and he thought that Mr Yeates had started to develop a risk management approach from the moment he arrived.

100. Mr Bell felt that, coming from a financial rather than a healthcare background, at this early stage in his role he was unable to have a broad view of the issues:

This was, I think, my third meeting... So I recall this subject being debated, and I recall from my – with my financial background thinking about it probably from a financial point of view. My wider view on these things probably didn't develop for a few months, I have to say.

101. Addressing the issue of risk assessments, Dr Wall, who had a public health background, said that he would have expected risk assessments to have happened but accepted that the minutes do not indicate that this was something which was acted upon, even though it was raise:

I would expect the work to be carried out; whether it would be documented, I don't know.

102. Dr Wall recollected giving *"quite a grilling"* to Mrs Harry about the impact on staffing of the clinical floors project; from this he had gained the impression she had no concerns about it.

I think it was her baby in that sense and she certainly gave me the impression that all this could be managed and a change in skill mix achieved and patient care could be improved at the same time.

103. None of the non-executive directors who were asked about it could remember being aware of any opposition or concern from the medical staff, and believed that if there had been any active opposition they would have heard about it. They relied on the presence of the Medical Director, at the time Dr Gibson, and the consultant staff committee chairman. They did not think there would have been any inhibition in raising such issues at the Board, even if it has been at a public meeting. They recalled that Mrs Fox, then a non-executive director, who had a nursing background had always been very strong in raising issues of this kind.

104. All the non-executive directors interviewed would have expected a radical decision to change the nursing skills mix on the medical floors to have been discussed by the Board, although the Inquiry could find no record of this having happened and none of the non-executive director witnesses could recollect it

happening. They remembered later that there were concerns about how elements of the project were working, but not that it was having an adverse effect on the standard of care. They would have expected concerns about the patient/staff ratio to have been drawn to the attention of the Board by the Director of Nursing or the Medical Director, but this did not happen.

105. Dr Suarez had been aware that there had been concerns about the clinical floors project before she became Medical Director but could not recall colleagues coming back to her with them after she took the post.

Comments

106. This project, which played an important role in reducing the overall provision of a reasonable standard of care to many patients, was approved by the Board without an adequate examination of its implications. Much reliance was undoubtedly placed on the advice of its chief proponent, Mrs Harry, but very little attention seems to have been paid to the opinion of anyone else. In a hospital where the clinical staff were said to be less engaged than they should, efforts should have been made to find out for themselves what staff thought. It was important that a project of this kind was 'owned' by the staff. There had been no adequate impact or risk assessment either to suggest potential difficulties or to identify measurable outcomes that would demonstrate satisfactory performance. Once it was set in motion, there was little proactive assessment of how it was working, with the Board relying on hearing of concerns. This was a risky approach in an organisation with a governance structure acknowledged to be weak. As my adviser on governance, Mr Richardson, pointed out, it is symptomatic of a Board that appeared to conduct business in a passive, certifying style and that did not appear to challenge and engage with key issues.

Workforce reduction and staffing issues

107. These issues have already been considered, but a few points taken from the evidence of Board members are instructive.

108. Ms Brisby had been unaware of staffing problems reaching back to the 2002 CHI report, of which she had no knowledge in any event. In relation to workforce reductions proposed and implemented in 2006, she had a clear recollection that the plan had been endorsed by Mrs Harry. She described walking around the hospital with her and two non-executive directors who had questioned her strongly on the issue. Her clear recollection was that they were assured by Mrs Harry that the changes would not be detrimental to patient safety. While the workforce reduction was driven by the financial crisis facing the Trust at that time, there was no sense that the proposed staff reduction itself would result in a crisis for the standard of care of patients, given the reassurances received.

109. She agreed that when Dr Moss arrived and took the view that staffing was inadequate and that a staff review was necessary Ms Brisby agreed that this presented an entirely different picture to that which had been produced previously and that it undermined her confidence:

It felt as though part of the job was to make sure we got the right people in post and that is not straightforward, but that was the direction which we moved.

110. Dr Wall recollected the proposal for a workforce reduction and believes he would have asked about the impact of staffing cuts. He remembered being assured that there would only be a minimal impact on clinical staff. The jobs to go were to be mainly "backroom jobs". Mr Bell thought that the only way the £10 million deficit could have been managed was with the help of a workforce reduction, but that:

lots of questions were asked about the extent to which we could minimise these... I guess I felt very much dependent on the assurance that I was getting from medical people on the Board that this was doable, and by doable I mean doable safely.

111. Dr Wall accepted that there had been a lot of pressure on the Trust from the SHA to balance the books at the time, as there was, he suspected, on the whole NHS. His understanding was that if the books were not balanced the Trust would cease to exist.

112. Mr Bell thought that the Trust had been put in an *"impossible situation"* by having to find cuts so urgently:

I was very taken with the fact that a lot of the information coming out of the NHS centrally seemed to be coming out later and later, and I can't remember exactly when the precise consequences of the new tariff were known. But I was conscious of the fact that this information was coming later and later and would make it more difficult to forward plan.

... Overnight it is the equivalent of saying: go out and find a heck of a lot of more – new customers, and it seemed to me that in the NHS that is extremely difficult because you are drawing patients from a locality and those two PCTs covered the locality.

113. Mr Carder recollected that the issue of vacancies was always coming up at Board meetings, as was the question of absence due to sickness. He said he had taken the view, which he expressed at Board meetings, that these were interconnected. He had been unaware that there were problems in obtaining reliable figures on staffing.

114. Mrs Harry's role in the workforce reduction proposals is fully considered in the section on that issue.

115. Dr Suarez pointed out that the workforce reduction proposal predated her time as Medical Director and that this was in any event more of a nursing than a medical issue:

It is true to say that I think nurses were much more affected than doctors for instance and yes, inevitably we were – there was a concern that finances were compromising the number of posts we had available.

Q: *And also compromising the quality of care that was being provided?*

A: *I think in hindsight it is much easier to link the two. At the time we were doing the best we could with the resources we had available and it was no more complicated than that.*

Q: *But are you saying that at the time that connection wasn't made?*

A: *By who?*

Q: *By you.*

A: *Well, I think we were aware that the number of posts had been taken out. We were aware that we had to balance our budget and we were also aware that we needed to re-look very carefully at the nursing numbers and skill mix, which is exactly what the nursing director did when she was in post.*

116. Ms Brisby's reaction to the level of concern about staffing issues on the medical floors was to await the outcome of the skill mix review being conducted by Dr Moss because of a degree of scepticism about the significance to be attached to complaints:

Until you have got a sense of what the staffing levels ought to be, it is often difficult to know what sense to make because again people will – this is not me being cynical or unreasonable or judging people's views – but mostly people say we could do with more staff here.

117. She rejected the suggestion that the review had taken too long and should have been given higher priority.

It was given a clear priority. There was no question that needed to be done. There was also no question that needed to be done properly and Helen – with any new executive post it takes a little bit of time for the new executive to bed in and start being able to influence things and make decisions. I think she got on with it as quickly as she could. I think the Board gave her the support she needed to have been able to do it.

118. Dr Moss's role in the skill mix and establishment review has been considered elsewhere and she has given her explanation as to why it took a long time to complete.

119. Mr Carder recollected Dr Moss proposing a skill mix review shortly after he arrived at the Trust. She was someone who expressed her views forcefully and for whom he had a lot of respect. However, he did not recollect that the impression was conveyed of something that was needed to be completed instantly. It had not been suggested to him that there was a serious lack of nurses, as opposed to a need to look at the skill mix.

Comments

120. The workforce reduction was agreed to at a time of maximum financial pressure. There may have been no alternative but to consider such a step but there is an alarming lack of evidence of the Board concerning itself with the assessment of risk or the impact on the quality of service. Assurances were accepted, principally from the Director of Nursing, but little if any challenge seems to have occurred. Indeed, there is no evidence of any systematic assessment of risk considered by the Board in relation to many changes.

121. Examination of what happened with regard to the skill mix review initiated by Dr Moss is instructive. It was initiated shortly after she started. Its implementation had not been completed by the time she left. It was commendable that she noticed so quickly that there was cause for concern which required systematic evidence-based analysis. What is troubling, however, is that there was no great sense of urgency in the process. While there were no doubt several reasons why individual stages of this process took so long, there was a failure to address more quickly an issue that was highly likely to impact on the safety and quality of care provided to patients.

122. On a more basic level, it is surprising that the Board never got to grips with the deficiency in accurate information about staffing numbers. This was surely one of the most fundamental tools of the Board's job.

The application for foundation trust status

123. The process towards seeking foundation trust (FT) status had started before the period under review, but had come to a halt. Ms Brisby's view on arriving at the Trust was, as has been seen above, that there were serious problems. She determined that the first step necessary was to recruit an executive team in whom she could have confidence. The decision to go for FT status followed on:

...as a way of making sure that the changes we proposed to make would be in line with what was commonly seen as best practice and subject to proper external scrutiny. Our clear objective was to ensure that we were providing the best possible service to patients and their families.

124. She perceived that the steps required to obtain FT status concerned putting in place good governance:

This was the main reason for pursuing foundation trust status, as the best means to a desired end.

125. She conceded that there were attractions in the removal of the obligation to break even that are imposed on NHS trusts, but she saw the endorsement of the governance systems by the external bodies that have to look at a Trust as part of the application process as the chief attraction:

Having a whole series of outsiders come in and go through our governance arrangements and give us feedback seemed to me to be a really, really valuable exercise.

Q: *Why was it valuable? Because you have already identified no effective governance, why do you need someone else to tell you that?*

A: *Because it is always useful to have external scrutiny of what you are doing and because I do not think any organisation can do everything for itself. I think it is just helpful to get tested and it was a very testing process. As far as I was concerned and I don't know this was true of everybody I didn't terribly mind whether we got it or not.*

126. She saw it as a way of persuading people to improve their standards:

Q: *Was there any sense in your mind that that was a more attractive way in which to persuade people to improve their standards than to criticise them for not having good standards?*

A: *I think that was quite a large part of it. I think it was helpful in all sorts of ways, in that it gave everybody a focus and a goal to aim for and brought people working together in ways they may not have otherwise, and it was actually – I think the whole feeling has changed since then completely because of the Healthcare Commission, but at the time it felt like a very positive and really quite exciting time.*

127. However, although there was no compulsion about restarting the process, Ms Brisby told me that there was encouragement from the SHA, consistent with what she understood to have been national policy at the time:

There is no question that the strategic health authority was very keen for us to apply. There is absolutely no question about that. Cynthia Bower was chief executive,[79] *she is now chief executive of the Care Quality Commission. She was chief executive for the strategic health authority. I would not say* [she] *put pressure on us because that would be unfair but* [she] *certainly was very, very enthusiastic about the idea of us applying.*

128. She did not think the process distracted the Board from its job:

The things that we had to do to apply for foundation trusts were things that we should be doing anyway. It was about making sure that the systems worked properly. So it wasn't other things, it was actually the job.

129. She made it clear that she considered *"the job"* to be ensuring that the right systems were in place which would ensure the quality of service, rather than being directly concerned with the quality of service itself: that was what she saw the FT application helping with:

Q: *Does it follow from what you were saying a moment or two ago that really the process of applying for foundation trust status was not itself particularly … concerned with the quality of service or care being provided?*

A: *Yes.*

Q: *So it was largely, if not exclusively, financial management, strategic-type considerations?*

A: *Yes.*

Q: *Rather than consideration of the provision of services or the standard of services being provided?*

A: *It was finance and governance and the governance bit would be expected to have systems in place to make sure it could pick up proper information about how services were doing. It wasn't actually about the services themselves.*

[79] Cynthia Bower was Chief Executive of NHS West Midlands July 2006 – July 2008

130. She pointed out that it was the Healthcare Commission's role to 'sign off' the Trust at a standard which entitled it to apply for FT status, and that it had done so. She saw that as confirmation that the Trust was providing a satisfactory service:

Q: *You saw the fact that the Healthcare Commission had assessed you as being in a position to apply for foundation trust status as confirmation of the Trust providing a good or satisfactory standard of service?*

A: *Yes. I am absolutely certain that if we had got the sense that that was not the case and the Healthcare Commission had got it wrong and actually we were providing a really poor standard of service, then that would have been a very different sort of discussion.*

131. Mr Hindley recollected that the Trust had been *"vigorously encouraged"* to pursue the application for FT status in 2005 by the then Chief Executive of Shropshire and Staffordshire SHA, David Nicholson.[80] He did not suggest that the SHA was the driving force behind the application but that it was seen within the Trust as a driver for radical change:

Q: *What is the significance that we are to attach to Mr Nicholson?*

MR HINDLEY: Simply that there was vigorous encouragement but in fact we already – Martin Yeates was in post, we already were anxious to bring about fundamental change into the organisation and broach the risk management, those sorts of issues. The foundation trust process was seen as a very appropriate aid to bringing in those many changes in approach that were necessary.

DR WALL: It was seen as the gold standard, and I think we all felt that we wanted to be up there with the best and certainly the foundation trusts were and still are, I think, seen as the best.

132. The encouragement included a 'rehearsal' in 2005 for the Board-to-Board meeting with Monitor, which was conducted by Mr Nicholson and Mr Sumara, then Managing Director of Shropshire and Staffordshire SHA. Mr Sumara remembered the occasion and described it as *"pretty challenging"*. He pointed out that a similar process at a neighbouring trust had resulted in the departure of the whole Board. Mr Sumara recalled having concerns:

Q: *What I am interested to know is this: this is the end of 2005, a time at which apparently we now know the hospital was providing standards of care which were not up to scratch routinely; we know that in 2002 there had been – end of 2002 there had been a CHI review which had identified many of the problems which might be thought to have continued – lack of nurses, lack of nurse*

[80] At this time David Nicholson was Chief Executive of three local SHAs – Birmingham and Black Country, Staffordshire and Shropshire and West Midlands South – which were being merged into one.

leadership, poor clinical governance, to name but three. I am interested to know whether you in your board-to-board meeting with them were able to identify those deficiencies or whether a completely different picture was being presented to you.

A: *Two parts to that really. One part is that my memory of their presentation is, I think it was described as a strategic-free zone, that was one comment I remember being said, in the sense that they didn't have a clear sense of where the organisation was going and I think that was in relation to Cannock Hospital and its future. The only other memory I have got of that* [there were] *some issues concern about their board members, including non-executives. I don't know whether they were changed or whatever. Did they have the strength of leadership and people on the Board that could go forward to foundation trust status. They were put in need to do a lot more work ... from that day.*

133. Indeed in a letter to the Chair dated 08 Jan 2006, Mr Nicholson expressed the SHA's view that the Trust was at least two years away from being able to meet the criteria for a successful application. The concerns expressed included *"gaps in control and accountability"* and a risk management system in need of improvement. In contrast, the non-executive directors understood this rehearsal as having satisfied the SHA that the Trust was fit to go forward with its application.

134. Mr Carder arrived after the decision to apply for FT status had been taken, and he thought his appointment had been related to in bringing to the Board his accountancy expertise. He thought that the fact of making an application must mean that the Trust was doing well:

Foundation trusts were held up to be the top tier of hospitals and therefore the simplistic view perhaps that I took at the time was, well, if we are going for that, we have got to get everything – we have got to be in that upper tier of hospitals and we will be looked at in some detail as part of the process.

135. Mr Carder was asked what the basis was of the declaration that all directors had signed on the application form that the Trust was providing a high quality service to patients. Hs answer echoed the reasoning process of Ms Brisby:

... we had gone through this Department of Health assessment process and they had deemed us to be ready, and everything I was hearing at the Board meeting was pretty positive. I was not getting anything from complaints, contact with the PCT or anything like that which was telling me otherwise. So I had no particular basis to challenge the assertions of the executives because most of the news we were getting was good news. We were tackling infection rates and things like that, which is obviously coming in from the outside. All the publicity you had, which tends to focus your view on the NHS, was MRSA, where is it going?

And we were on a downward trend. We were not brilliant – compared to where we are today it wasn't great – but it was going the right way and we were meeting the targets set by the Department of Health et cetera in that area.

136. Therefore as a director he felt that this view was confirmed by the fact that the Trust was successful in its application.

Frankly we were all feeling very pleased we got through the process. The process is held out to be extremely rigorous and a lot of organisations fail.

137. While he appreciated that financial issues had been the focus of the FT process he also thought that poor care could not continue for long without showing up in poor financial performance:

There was obviously a financial element to it, and if you talk to Bill Moyes [Executive Chair of Monitor]*, he has that kind of background which makes him interested in finance. But the impression I had, whether it was right or wrong, was that all aspects of the hospital were being looked at. You can be as profitable as you like, but if you are not caring for your patients then you won't be profitable for very long because they will all go away.*

138. Dr Gibson appeared somewhat lukewarm about FT status. He believed there had been some pressure from the Department of Health on the Trust to go for FT status, when the first attempt was made, but he was rather vague on why he thought that. He remembered Mr O'Neill having a letter, which he, Dr Gibson, had not read. He felt that the independence that went with FT status would be an advantage but the disadvantage was the huge amount of work entailed in getting there, and the danger of:

...taking our eye off the ball of what we are doing now. So we developed two teams. Nevertheless, everyone will tell you that foundation status requires a vast amount of work.

139. The matter had been discussed with the consultant body, which was finally swayed by the perceived advantages of financial independence.

140. Dr Suarez also saw the application process as a way of getting systems in place, and did not think it had been much of a distraction from the work of the Trust:

By the time I joined, it seemed not a distraction so much as an opportunity to get our systems in place and correctly, and if we could do that with foundation trust, that would stand us in good stead, particularly around governance and assurance. It was hard work and a lot to do but I am not sure we regarded it as a complete distraction. It was something as an aid for getting ourselves up to speed for purpose.

141. Dr Moss also thought that the process of application helped in improving governance:

I thought that the FT application process helped with getting the governance structures in place.

142. She did not think that the Board was distracted by the application process from dealing with clinical issues, even if the minutes of the Board did not reflect that view.

Comments

143. It is a striking feature of the evidence that the Board members collectively and individually seemed to believe that an application for FT status was a means to the end of improving the Trust's governance structures, as opposed to being something to aim for when the Trust was in a fit state to be granted that status. This seems to have led to a collective complacency in believing that the systems being put in place as a result were sufficient and that the approval of external agencies such as the SHA was in itself confirmation that all was well internally. The division in directors' minds between the strategic and operational functions seems to have led to them failing to find out whether the systems were in fact working to ensure safety and good care.

144. I have no doubt that the process of the application did detract the Board's focus from other issues and that the imperative of success led it to attach less importance than was appropriate to the concerns of which it was aware.

145. I do not believe that directors set out to deceive with the declaration in the application form as to the quality of care being provided, but the fact that they did so reveals a profound misunderstanding of their responsibilities in this regard. They placed an ill-judged reliance on the assessments of external agencies, when to a large extent these were relying on information generated by the Trust itself. This could be no substitute for finding out for themselves. Their focus seems to have been on processes rather than on real outcomes.

Public engagement by the Board at meetings

146. As an NHS Trust, Board meetings were held in part in private and in part in public. NHS Trust Boards are entitled to sit in private by virtue of legislation which allows a Board to exclude the public:[81]

[81] Public Bodies (Admissions to Meetings) Act 1960, section 1(2)

Whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the proceedings.

147. In its helpful written submissions, Cure the NHS has drawn my attention to the type of item which was discussed in the private section of the meetings. They included a possible health and safety prosecution of the Trust, a serious incident resulting in the death of a patient, the possibility of the Trust restricting access to treatment for patients from a particular SHA area, the overrunning of a decontamination initiative, and even the Trust's Scottish dancing club. It was submitted that there was generally an impression that any 'bad' news was discussed in the private part of the meeting, and the 'good' in the public part.

148. When FT status was granted, initially the Board sat entirely in private.

149. The Head of Legal Services and Trust Secretary, who started in May 2006 from a background of having been an employment law specialist, told me that at that time there were both private and public meetings, but that there was a desire to change this as the Trust approached FT status:

I know from when I started, there was a desire to move to having everything in private and therefore I never spent any time looking at whether – what was in private or public, it was split correctly. I didn't have the experience to just look at it and know. So I was working on the basis that very shortly everything was going to go into private... when I arrived, the Chairman and Chief Executive both wanted all board meetings to be in private, and that is what they were moving towards...

I think in outline [there was some consideration that] *as a foundation trust we would have a choice. As a foundation trust, we were going to be more commercial and we would be discussing commercially sensitive issues and that the Council of Governors would be our public meeting.*

150. Her personal view was that it would be preferable to sit entirely in public or in private. In the end, the decision had been that after each private FT Board meeting there would be press briefings, and it was recognised that the public would have access issues discussed at to governors' meetings.

151. Mr Carder's explanation for adopting private meetings as an FT Board was that:

I think there was a view that we were now in a more competitive business environment with other competing hospitals and we didn't want to reveal commercially sensitive information and I think the other – it was quite common, we understood, among other foundation trusts at the time. The other issue was that the public Board meetings were just appallingly attended. The press didn't turn up, we sent them a press release. And you were lucky if one or two people turned up.

152. He could not recollect there having been any dissenting voices, and he did not find this striking as in the commercial world he was used to, all board meetings were in private. It was the idea of sitting in public that was novel to him. He argued that there were business aspects of the work of the Board even though it was a public service organisation, but on reflection he agreed that matters such as staff absenteeism and feedback about complaints were not quasi-commercial issues of this type. As a member of the current Board he had been converted to the desirability of public meetings:

Having experienced what I call proper public board meetings, actually they are quite refreshing... there was a lot of nervousness, particularly among the executives I think, about that, and David Stone who was the interim Chairman, said: no, we are going to have public Board meetings; and we as the non-executive group supported that. We had our first public Board meeting, we had television cameras, we had radio, we had the press, we had Uncle Tom Cobley and all and actually we just got on with it, and it was kind of a bit of a sort of thing on the road to Damascus, almost. We all suddenly realised: what is the problem? There really isn't a problem. We do hold parts of the meeting in private if there are things where we need to discuss disciplining matters about consultants or things like that where we have got to talk about individuals, and we don't want that to get in the public domain. But pretty much all our meetings are now held in public. And it is quite interesting. And we get some quite interesting questions. And some quite insightful questions, sometimes, from the public which help us with our deliberations.

Comments

153. I agree with the submissions of Cure the NHS that far too much Board business had been conducted in private. While sensitive issues about individual patients and staff may well need privacy as may some genuinely commercially sensitive issues, very few issues need not to be referred to at all in a public session. For example, the results of a serious untoward incident can be presented in public once the process is complete. Similarly, an issue of staff discipline can sometimes be addressed in this way. It is important that the public does not

gain the impression, as has happened here, that only good news is discussed in public while the bad is hidden behind a curtain of secrecy. Had the Board sat in public and been more open, it would have been more likely that concerns would have reached Board members' ears. An open culture at the top encourages one throughout the organisation and beyond.

Reaction to the Healthcare Commission investigation and report

154. Before the publication of its report, the Healthcare Commission (HCC) wrote a letter to the Trust on 23 May 2008 which was highly critical of A&E. This was met with surprise by the non-executive directors who told me that they had not realised that matters were that serious, although they had been aware of issues in A&E. They had been unsure whether these were temporary and attributable to the refurbishment or were longer term. The directors' approach to targets has been considered in the culture section; they told me they had certainly not intended to prejudice patient care by emphasising the importance of the waiting time target.

155. The non-executive directors by and large felt that the Trust had been unfairly treated by the report, and perhaps more so by the public reaction to it. They did not deny that there had been matters discovered which raised justifiable cause for concern, but the general impression conveyed by them was that they felt that, had they been given a little more time ,they would have succeeded in sorting the problems out.

156. Dr Wall did not deny that there had been failure of care in certain areas, but:

My big issue with the Healthcare Commission report is that it gives the impression that there were systemic – systematic failures, which I don't believe, and that it was, if you want, a failing trust and it wasn't a failing trust.

157. He accepted that there had been many complaints but did not accept the conclusion drawn from them by the HCC:

There were a lot of complaints of poor standards of care in specific areas over a period of time, but I do not see that as a systemic or systematic failure.

Q: *What is it? It is just individual nurses on each occasion failing to do their job properly?*

A: *I think that is probably it, yes.*

158. Mr Hindley put the same point even more strikingly:

I have vivid recollections of a very early meeting of the new Board of Governors when Mrs Bailey and a number of her colleagues attended. That was the most harrowing experience I think I have ever been through and all of us were there.

MR BELL: Yes.

MR HINDLEY: I will be quite open and honest about it, I had no idea about the magnitude of the problem before that meeting, but by hell did I when I left that meeting. It was harrowing. But to project that and say that the whole of the organisation was failing, I think is a gross overstatement.

159. They went on to accept that the stories told at the governors' meeting did mean a systemic failing had occurred in specific wards but that it did not mean there had been a failure across the whole organisation.

Q: *Your point would be that it is unfair to tar the entire hospital with the brush of bits that have gone wrong?*

DR WALL: Yes, and that has put it very well. That has put it very well. These were serious failings, I fully acknowledge that. If we would have been aware of these, my gosh, if we would have been aware at the time, we would have been horrified and we would have done something about it. We weren't aware at the time. But I am concerned that the Healthcare Commission report, I do not think it actually uses the phrase "failing hospital" or "failing trust" but it certainly gives that impression and it was not a failing trust.

160. Mr Bell expressed more bemusement:

I thought about it long and hard over the last nine months or so and I suppose the thing I can't quite come to terms with is the fact that we have been so heavily scrutinised, both through the foundation trust process [and before it], by many organisations... we take assurance from many different areas, including our own personal experiences and those of our families, friends, acquaintances and whatever and I still to this day do not understand why we were not aware of these issues and I find it astonishing that nothing was said to us, that none of these investigating or scrutinising bodies found even a glimmer of evidence of these issues; that in our informal contacts with doctors and nurses around the hospital, that nobody ever said anything about these issues. I just find it astonishing and I have no explanation for it.

161. These directors thought that, while the Board had to take ultimate responsibility for what happened, it was not unreasonable for it to have relied on the assurance of the executive directors and members of staff:

MR HINDLEY: The Board has to take ultimate responsibility for everything. I do not think any of us would want to shirk away from that. But several times throughout today in our responses we talked about assurance, where we took assurance from. Certainly I think it is not unreasonable to expect that the non-executives should take considerable assurance from the executives.

MR BELL: And lots of other bodies and people.

MR HINDLEY: It has hardly been mentioned, medics. It has not been mentioned but we have been insisting for sometime and they have finally done it, just; we have a full-time medical director. That was a major step forward. That took nine years for the Trust to get a full-time medical director. I saw that as probably the most positive thing that has happened in the organisation.

162. Ms Brisby contended that:

We succeeded in turning the Trust around, as has been more than demonstrated by the very good results just published relating to the last year of my chairmanship. With an organisation of some 3,000 employees and a budget of £140,000,000 this could never have been an overnight process... [The Trust] *was poised to become not just an ordinary district general hospital but an outstanding one... many of the issues highlighted by the investigation were already being addressed by the Trust despite the additional pressures on management due to the investigation process itself. For example, the Trust's plans to develop the assurance frameworks at divisional level in 2008 had to be deferred until 2009/10.*

163. Asked to justify this assertion, she pointed to the appointment of a strong executive team , including Mr Yeates, whom she described as good Chief Executive, Dr Moss as Director of Nursing and Governance and Dr Obhrai as Medical Director, and Sir Stephen as a non-executive director. She considered that governance had been strengthened and financially the Trust was:

OK, we could afford to do things that needed to be done and to put investment into the future.

164. She questioned the validity of the HCC's findings:

I think the evidence base for their findings was really, really dubious and the outcome was a very damaging one.

165. However, on being questioned further about this statement, she conceded that her criticism was more about the process adopted by the HCC rather than its findings:

Q: *It might be thought that in your reaction... that they didn't have enough of an evidence base and so on is one... about which no doubt there can be an argument. Do you think that your approach recognises sufficiently from the positions of Chairman of the Board the impact of what has gone wrong on the patients?*

A: *... I think the challenge would have* [to be] *on the basis of the way the report was produced. I am in no way denying that things had gone wrong. It is perfectly possible to do both.*

Q: *That makes it sounds as if it is more a concern about process rather than the outcome?*

A: *Yes I think it is about process, but I also think it is about balance and fairness and the impact on the organisation.*

166. The former Chief Operating Officer also considered that the HCC did not sufficiently recognise the good practice at Stafford:

I do not think [the HCC findings] *came as a surprise, I think it came more – language that was used and perhaps the lack of balance was a shock rather than a surprise...It saddened me. There is a difference between surprised and being disappointed... Because as a human, anything that reads so appallingly without any reference to any improvements or anything, that any actions that were taken, then, I would not be human if it didn't sadden me.*

Q: *But surely what is sad is that it was happening at all?*

A: *Yes, but I think there is an issue around putting into basis some of the context and the scale, because it is not* [that] *every single patient had a bad experience in the hospital... And yes, it is unacceptable that any patient has a poor experience... But when all you are reading is that document, it doesn't cite very many areas of good practice.*

167. Mrs Harry did not agree with much in the report in the sense that it did not match her perception. While not denying the specific findings, these were not matters of which she was aware:

I am saying the way in which it was reported in the Healthcare Commission report and some of the things just did not resonate with me. I am saying that if I had seen any of this practice, I would have picked up on it. My staff were out and about on the wards all the time and I am sure, had they seen poor practice, it would have been – they would have raised it with me and did at times raise it... I challenged some of the things within the report. I have no doubt that when the Healthcare Commission went in in 2007, they saw what they saw. I think what I am saying is that what they saw in 2007 – some of it may have been going on in 2006, and I, you know, hold my hands up, and that might have been the case.

I think equally what I am saying is: had I known about it, I would have done something about it. And particularly, had I known about it and it had been as bad as was reported in the Healthcare Commission report. And I think if things had been that bad, I think it is highly unlikely that it would have gone unnoticed by me or by my staff.

168. Dr Gibson was surprised at the report, and *"horrified"* at the evidence of patients and their families to the Inquiry, the summaries of which he had read.

169. Dr Suarez was not entirely surprised about what the report had to say about the clinical floors project, as there had been concerns about that and the shift in skill mix from before her time as Medical Director, but she had not been aware of the extent of the other issues raised. In so far as she was aware of them, she considered that she had been trying to address them.

170. She accepted the criticism that action being taken by the Trust to address some of the issues, such as the skill mix review, had been slow:

A lot of the criticism that the Healthcare Commission makes, a lot of the things that we were doing, we weren't just doing fast enough, but there was an awful lot to do all at once. So, yes, it took a long time; there were a lot of other things to do at the same time and we wanted to do this correctly.

171. She accepted that the challenge and discussion at Board level could not have been effective in the light of what the HCC found, and that if the Board had been aware of the extent of the issues it would not have permitted them to continue. With regard to the A&E issues of which the Board was aware, she accepted with hindsight that the Trust should have got on much more quickly with addressing them than it did.

172. Dr Moss was more accepting of the report. She thought it did not contain very many surprises although she thought it could have been more balanced.

I think that the balance wasn't there around things that had been put in place to change and to move practice forward. I didn't think that that was accurately reflected, although a lot of that hadn't come to fruition; changes were being made and I do not think that was reflected in the report.

Comments

173. Unhappily, the view of nearly the whole Board can be characterised as one of denial. Board members have shared a fallacy common among many witnesses from the hospital in considering that the HCC was been unfair because it did not recognise good practice where it occurred. No one has denied that there has been good practice: the HCC report was prompted by and focused on concerns about emergency admissions, although it identified wider concerns as a result of its investigation. It found perhaps less cause for concern than has this Inquiry. Further good practice in one part of a hospital does not mean that there are no systemic failings in another. The Board's reaction to the HCC investigation, as reported by the Board and as confirmed by this Inquiry's review of the Board minutes and other evidence, was one of complacency, of believing that issues were being addressed. There was inadequate appreciation of the requirement of urgency in addressing issues of which it was aware. In short, there was an alarming lack of insight and an absence of reflective attitudes.

The Chief Executive

174. Mr Yeates has not given evidence to the Inquiry in the sense that he has offered no statement specifically prepared for it and has not attended an oral hearing. As indicated in the Introduction to this report, I am satisfied on medical evidence that he is unfit to participate. However, he authorised his solicitor to disclose certain documentation and other information to me. Foremost among this has been a statement prepared by Mr Yeates for the investigation undertaken on behalf of the Trust in March/April 2009. The statement provided helpful evidence as to Mr Yeates' position on the findings of the HCC report and his performance as Chief Executive, and requires summarising here.

175. Before his appointment, Mr Yeates had executive experience at nearby Trusts as Director of Contract and Clinical Services, Director of Hospital Services and Director of Care Services. In his CV, submitted as part of his statement to Mr Garland he listed among his achievements:

- *Led* [the Trust] *from a failing organisation to Foundation status in a two-year timespan.*
- *Led the Trust through the intense scrutiny of an investigation by the Healthcare Commission.*

176. In his statement Mr Yeates put forward a case which included the following overall points:

- He had *"been appointed to a failing organisation lacking in any governance arrangements and suffering from poor leadership."*
- It had become apparent there was a *"major underlying financial deficit"* in 2006/07, a year in which the NHS was required to balance its books.
- He asserted that over his period in office *"the organisation has been turned around to one with a sustainable future, embedding robust governance arrangements and improving quality and standards of care."*
- He accepted that there were *"examples of poor care subsequently identified as being delivered in some of the hospital services, primarily during the curse of 2006/07. However, this should be put in context of an organisation where at the point of the Chief Executive's appointment there were no systems or processes, a lack of standards and protocols, no training and development, patchy and inconsistent staffing arrangements and no performance controls or management. Remedial action was required in all of these areas and action either has been taken or is work in progress."*

177. Mr Yeates asserted that he had provided a strategic direction to the Trust by developing an integrated business plan which included market assessment, vision and strategy, service development, staff development, finance and governance. With regard to governance Mr Yeates said that on his arrival there were only limited arrangements in place:

There was no risk register or assurance framework, the complaints process was inadequate, clinical incidents were not reported, clinical audit was ineffective and there was no information governance. There was no ownership of any of the governance issues within the clinical directorates. There were no central governance support structure arrangements other than a complaints manager,... This situation resulted in no information being provided to the Trust Board and a lack of clarity with regard to key clinical standards, for example clinical outcomes, mortality and quality of care.

178. This deficit was addressed, he said, by developing strategies in all these areas and governance groups.

179. Mr Yeates noted that in 2007/08 concern had been raised about mortality and the Hospital Standardised Mortality Ratio (HSMR) of 127 for 2005/06. He said that reports from Dr Foster Intelligence and CHKS confirmed that overall mortality was within the national average:

and therefore the focus of attention was related to data capture and coding.

180. He referred to the work done by the SHA and the University of Birmingham. He also pointed to the improvements in infection control which resulted in a reduction in hospital acquired infections of 70% in 2009, compared with 2005/06.

181. He stated that he had been instrumental in changing an ineffective executive team and had recruited a number of departmental heads.

182. Where quality of care was concerned, he noted that a new Director of Nursing had been appointed and that the skills mix review had been launched, which identified a shortfall in the numbers of nurses and of skills. He thought that the introduction of basic nursing systems and measurements had an immediate and sustained effect on care standards, as had the increase in workforce resulting from the staff review.

183. Where the FT application was concerned, he stated that:

The focus on FT resulted in the development of a variety of key issues including development of the Board and development of governance arrangements... The further development of trust status was a focus of attention during the course of 2007/08...

184. He acknowledged that there was further work to do on the Trust's culture, which he described as having been:

very inwardly focused and complacent... resistant to change, innovation and development, accepting of poor standards and with relatively low professional esteem.

185. With regard to the HCC investigation, his view was that:

- Although the HCC focussed its attention on a number of issues, for instance A&E, many improvements had been put in place or were in progress which they did not take into account.
- The care issues identified had been incorporated into a plan: Confidence in Caring, which had been supported by Sir Stephen Moss.
- The skills mix review had resulted in the recruitment of more staff.
- A hygiene inspection had revealed no breaches of the hygiene code.

186. Where mortality was concerned, he pointed out that the 2009 HSMR was reduced from 127 to 88 – i.e. better than average.

Comments

187. Insofar as Mr Yeates' statement addressed issues considered in this report, it needs to be compared with the evidence the Inquiry has received from patients, their families and staff at all levels, as well as the findings of the current executive team. Whatever Mr Yeates may have believed had been achieved by the time of his departure, concerns about patients' experiences and of staff about governance and staffing issues had not been resolved in reality. Mr Yeates, like some of his erstwhile colleagues, seems to have focused on systems. While this is perfectly understandable, particularly where none have existed before, there was clearly a need for senior level management to be deeply involved in what was actually being delivered by way of a service, until they could be satisfied that the systems were actually working. It is also difficult to obtain a sense of any appreciation of urgency from what Mr Yeates has said, or of any expressed concern for the fate of individuals who have suffered from poor care. As with some of his Board colleagues there is a suggestion that the application for FT status was a driver for improvement, rather than a benchmark to be obtained once improvements were in place and working.

188. Mr Yeates' solicitor submitted to me that the persistence and willpower required to make the changes Mr Yeates made should not be underestimated. His solicitor suggests that it is accepted that he left the organisation in better shape than he found it and that the turnaround process he was conducting was incomplete at the time the HCC intervened. He informed me that his client would, if circumstances had allowed, have accepted responsibility and shared accountability with others. Mr Yeates accepted that Wards 10, 11, and 12 and A&E were performing very poorly and that as Chief Executive he was accountable for that. However, that accountability includes the duty and right to give an account of the situation and the steps taken to deal with it, all put in context.

189. There can be little doubt that, if Mr Yeates and his colleagues failed to get to grips with some matters, they did address others. It might be thought that infection control was one of them. Financial instability is another. Nonetheless, it is striking that the long lists of concerns produced by Ms Brisby and Mr Yeates – and they are similar lists – are also remarkably similar to the concerns identified towards the end of his period as Chief Executive by the HCC, as well as in the course of this Inquiry. The question has to be asked whether such problems, having been appreciated at the beginning of the period, should have been resolved by the end of his tenure. The answer surely has to be a simple yes.

Departure of the Chair

190. The Board minutes for 16 March 2009 record that Ms Brisby had retired. When asked about the circumstances of her departure, she told the Inquiry that she had in fact resigned on 3 March because, on 27 February, she had been telephoned by Mr Moyes, Executive Chair of Monitor, and was told that he intended to use his statutory powers to remove her because of the findings of the HCC. When asked to explain, he had merely said that he had to treat the HCC findings as fact. When, shortly afterwards, she informed Mr Moyes of her intention to resign he thanked her for being so reasonable. She said that she received no termination payment of any kind, and that there was no right to any.

Comments

191. Clearly, chairs of trust boards must be accountable for the success or failure of the organisations they lead. However, it is open to question whether it is in the public interest that there is no due process conducted by which the public can hold public officials to account and by which individuals subject to criticism have a chance to put their case and have it considered. These posts are too important to be governed to the extent that they currently are, by presentational issues. A swift dismissal such as Ms Brisby's may be efficient and convenient for the organisation involved, but it allows for no debate about the rights and wrongs of an individual's stewardship. There is also a danger that the sort of treatment that currently occurs in situations such as this deters suitable candidates from seeking these positions.

192. This is not intended as a criticism of what actually happened here, as the system in place provided no practical alternatives. The question is whether it should do so.

Departure of the Chief Executive

193. Considerable concern has been expressed by patients and their families and in the media about the circumstances of Mr Yeates' departure from the Trust. Normally, issues relating to the termination of employment of an employee, even one as senior as a Chief Executive, would be regarded as confidential. However, I consider that there is a strong public interest in the events leading to Mr Yeates' departure being placed in the public domain. Mr Yeates has, through his solicitor been given an opportunity to supply information, and much of what appears below is based on that information.

194. The Trust made available to me the relevant minutes, and I have also received information from the interim Chair, Mr Stone, who took the lead in this process. When it became clear that the HCC report was going to be highly unfavourable, Mr Yeates offered to 'step aside' from his post. It was not his intention to resign and initially he believed that he would be able to return and would be supported in doing so.

195. On 16 March 2009 the Board was told, according to the minutes that Mr Yeates had resigned. The Remuneration and Terms of Service Committee met later on the same day as that Board meeting. A different position was reported there – namely that Mr Yeates had:

...left the Trust, stating he was prepared to step aside but was not resigning. He had confirmed to the interim Chair verbally that he was to prepared to resign. The inerim Chair had spoken with Monitor, the Secretary of State and the Chief Executive of the NHS. He had explained the position to them and the fact that the Chief Executive was not on notice. The proposal was that the Chief Executive be suspended pending an investigation into the serious failure of the Trust identified in the Healthcare Commission report.

196. This was agreed. Mr Carder told me that he thought that it had been assumed that Mr Yeates was not coming back, thus the use of the word *"retiring"* in the minutes of the Board. A letter was sent to Mr Yeates on 17 March giving him notice of the decision to suspend him *"pending an investigation into the serious failings of the Trust whist you were Chief Executive Officer identified in the Healthcare Commission report."* He was also notified of the intention to appoint an external investigator.

197. A report was then commissioned from Mr Garland, a retired Department of Health official, who was asked to investigate whether there was a prima facie case for taking disciplinary proceedings. Mr Yeates supplied Mr Garland with the statement summarised above, which set out his position with regard to the criticisms that had been made, and challenged the findings made by the HCC.

198. Mr Yeates was also interviewed by Mr Garland. I am informed that following the interview, Mr Yeates took the view that he would not be getting a fair hearing and that it was impossible for him to return to work as Chief Executive. He also discovered that whatever support he believed, rightly or wrongly, he had from outside the Trust, he no longer had it. He resolved to seek a negotiated departure.

199. While a redacted copy of Mr Garland's report has been released as a result of a request under the Freedom of Information Act, the Trust has supplied a full copy to the Inquiry. The report reviewed the performance of Mr Yeates and concluded that there was a case to answer in disciplinary proceedings for potentially serious failings in leadership.

200. Mr Garland accepted that action had been taken to address many of the issues raised by the HCC report and that leadership of the Trust had improved since 2005 – and articularly since 2008 – but:

We have not seen or heard evidence to subvert the HCC findings that there were significant failings in the leadership and management of the Trust over the period covered by their report and in particular the failure to focus adequately on the safety and quality of care, and these contributed to poor clinical care. The Chief Executive had a preeminent role in the leadership of the Trust... and must bear a commensurately large share of the responsibility for these failures...

201. With regard to governance, Mr Garland noted that:

The Chief Executive inherited little in the way of governance arrangements in 2005 and things have since improved. Nevertheless the HCC criticisms remain and the Chief Executive must carry responsibility for the failings in systems and processes they uncovered.

202. With regard to the information provided to the Board he noted that:

We did not find any evidence from the papers we examined that the Trust Board was intentionally misled. There is, however, evidence that the information that went to the board was in some very important respects incomplete and inaccurate and there were similar issues with the Council of Governors.

Overall the quality of information and therefore the quality of discussion and decision making on clinical issues... was inadequate and compared unfavourably with that on finance and targets which occupied far more of the board agenda. This was unacceptable and responsibility for this rested in large part with the Chief Executive.

203. Mr Garland accepted that there was mitigation, as follows:

- Mr Yeates had inherited very difficult issues.
- There had been significant achievements.
- The HCC acknowledged that there had been considerable progress in A&E.
- He had overwhelmingly positive appraisals from the Chair, with little hint of criticism, even after the start of the HCC investigation.

204. Faced with this report, the Board – or more pertinently the Remuneration and Terms of Service Committee – had to decide whether to follow the logic of the report and start disciplinary proceedings against Mr Yeates or to seek a negotiated departure. They chose the latter course, having received legal advice. The minutes of the meeting of the Committee on 15 May 2009 set out the reasons:

It offered value for money and would allow the Trust to move forward with the recruitment of a new chief executive officer.

205. Accordingly, on 15 May Mr Yeates wrote a very short letter tendering his resignation with effect from 14 June, meaning that his last day of employment (taking account of his notice period) was to be 14 December. He received his contractual remuneration for that period.

206. The Inquiry asked the members of the Board about the reasons for this decision.

207. Mr Carder's view was that the Garland report was not unequivocal. For example it recorded the view of the previous Chair that Mr Yeates had been the best Chief Executive she had ever worked with. His conclusion was that:

We needed to get rid of Martin as cheaply as possible.

208. Asked for his view of Mr Yeates as a Chief Executive, he replied:

Martin was an interesting character. By then he had been completely vilified in the press. He had actually done some quite good stuff for the hospital because I have seen him working. For example when he got hold of infection control, infection control went down seriously and he was quite driven like that. He used to – he was a man who worked very hard, would be in at 6.00am, have a walk round the wards and then get on with his day job. But at the end of the day he was missing stuff. He was either missing it – and you ask why a chief executive is missing serious failings like this. It is difficult to know whether he – whether the system wasn't pushing stuff to him and was it failings of other executives or was it getting to Martin and Martin didn't like the idea of his hospital not doing very well and therefore was keeping a lid on certain things. And I don't know. Either way it is a serious failing as a chief executive to not have spotted these things and brought them to the Board's attention and therefore he had to go. But he wasn't all bad. I think a degree of balance on Martin needs to be had because he had done quite a lot of good things for the hospital.

209. In his view it was not fair to impose all the responsibility for what went wrong on Mr Yeates' shoulders, and that the other executive officers should share in it. However if, as Mr Yeates claimed in his statement to Mr Garland, he had inherited problems from his predecessor and had been doing his best to put them right when he ran out of time because of the HCC investigation, Mr Carder thought that he ought to have told the Board about it, and that he had been given reasonable time in which to sort things out. Even so, he considered that it was in the best interests of the Trust to avoid the costs, uncertainties and delays of a contested disciplinary process. He did not agree that there was a public interest in holding Mr Yeates to account in that way. He could not see what such a process would have added to the investigation and report of the HCC.

210. This view was supported by Dr Gibson, who also referred to praise of Mr Yeates, and himself thought that if he had been given longer he would have addressed the problems.

211. Sir Stephen Moss, who was a non-executive director when this decision was taken, was more reflective:

It felt the right way forward at the time because the driving force around everything that we were doing at that time was "we have got to make things better in this hospital for patients and we don't want any process in place that is going to detract our attention from that". We obviously took into account the legal advice, and this was one of the options that we could go with and the decision was made to go with it. In hindsight, looking at things now with the benefit of hindsight, would we have done things differently and I have to say possibly yes, because I am – I have increasingly become aware that we had a report that said there was a case to answer, and we didn't pursue that.

212. Mr Sumara, although he had not been there at the time, considered that they had had little choice. He thought that the Garland report was inadequate and a weak basis on which to launch disciplinary proceedings. Contested proceedings would have been lengthy and costly. He and Sir Stephen agreed that a much more detailed investigation would have been required. Mr Sumara thought that there were inadequate processes in any trust to deal with this kind of situation.

Comments

213. As commented above, the *Code of Conduct for NHS Board*s is not a very satisfactory document when compared with the codes that govern registered medical practitioners and registered nurses. In particular, while it mentions the priority to be given to patients it does not translate this very successfully into specific obligations in the way that, for example, the General Medical Council's *Good Medical Practice* does.[82] Mr Yeates was in effect forced out without a disciplinary process by being offered terms he could not refuse. He could have been forgiven for believing that any such process would lead to a predetermined result in view of the steps that had been taken before he tendered his resignation. That he may have been found to have a very high degree of responsibility for the failings of the Trust does not mean that he should not have been offered a fair opportunity to state his case. He made a detailed and reflective statement for the benefit of the Garland investigation but this appears to have been considered no further.

[82] General Medical Council (March 2009) *Good Medical Practice*, London: GMC

Overview of the Board

214. Sir Stephen Moss and Mr Sumara were asked for their views of the Trust when they took over. Their opinion, in summary, was that they found:

- An *"overwhelming sense of denial... characterised by 'it is not our fault, it is somebody else's'"*.
- An impression of a belief that everywhere else is just the same, but they have not been caught.
- A system of governance that was confused about who had responsibility, where decisions were made and how the Board got its assurances and from where:

  "if you looked at the chart that was produced as part of the flow of decision-making, the different committees, it looked as if you had thrown half a dozen spiders on to a piece of paper, having been dipped in ink, it was so confusing".

- A lack of focus on the job of a hospital:

  "it is a hospital, we care for patients. It is a relatively straightforward job and hospitals exist to care and heal patients and they have no other purpose apart from employing staff, but that is a consequence".

- A confused agenda to the extent that an executive team could have a meeting with no item addressing the issues to be faced.
- An overwhelming sense of lack of clinical engagement.
- Very poor and unclear lines of accountability.
- A sense of a closed organisation:

  "not listening and not welcoming external scrutiny, closed board, no contact with any other hospital in the vicinity".

- Poor financial information and governance.
- Poor leadership including lack of visible leadership at ward/floor level.
- Areas which felt unsafe.
- A *"mechanistic and defensive"* and *"absolutely useless"* complaints system.
- A lack of insight and a focus on the wrong priorities by the Board.
- A lack of clear direction.
- Poor workforce information.
- Examples of appalling behaviour by staff at all levels (some of which he personally experienced).
- Staff working in isolation from each other.
- A poor emergency care system.
- Poor staffing levels.
- A surprising continuing level of poor basic care.

215. Mr Sumara commented on the Board's lack of insight and its focus on the wrong priorities:

The previous board, in both the documentation we saw and in away-day material that they produced, saw themselves as successful, having achieved foundation trust status, and talked more about acquisition rather than patient care. This sense of our role is to go out and take over other hospitals rather than to get it right.

216. This was a board, both executive and non-executive which identified correctly the problems when they took over. Much appropriate work was done in an attempt to put this right. The task was a challenging one given the entrenched nature of some of the issues. The Board's collective failure was perhaps that of never fully appreciating the risks to patients that were being taken on a day-to-day basis as a result of the deficiencies that they were seeking to tackle but had not yet dealt with. Thus, not only is there little reference in Board minutes to quality issues, as Mr Garland found, there is also little sense of urgency, for example in the time taken to complete and implement the skill mix review. There was a degree of self satisfaction, amplified by the achievement of FT status, and a failure to detect or react to the ever-strengthening wind of concern that blew round the Trust. I firmly reject the contention of Cure the NHS that this Board was *"duplicitous"*. They all, Chief Executive and Chair included, acted in good faith. However, it would be true to say on the basis of the evidence accumulated by this Inquiry and the HCC investigation that they lacked insight and focus on the first priority of a healthcare service: its patients' welfare.

PATIENT STORY

I heard from the bereaved daughter of a 67-year-old woman whose mother sadly passed away in 2006. She described her mother with great affection as *"an incredible lady who had an absolute heart of gold and would have helped absolutely anybody"*.

She told me that her mother was diagnosed with bone cancer in March 2006 and subsequently underwent chemotherapy, which seemed to be going well. However, in the summer of 2006 she began having trouble with mobility and had a fall. She was referred to Stafford Hospital by her GP and was admitted to the emergency assessment unit until she was transferred, the following day, to Ward 2.

Her daughter recounted incident after incident of poor nursing care on Ward 2. On her transfer to Ward 2, her family requested that she be placed in an isolation bay due to her suppressed immune system because of chemotherapy. However, nurses informed them that this was not necessary and there was not the capacity even if required. After a few days, however, she acquired *Clostridium difficile*. The family were not told about this and only became aware of it by reading their mother's medical notes that were kept at the end of her bed.

Her daughter told me how her mother experienced severe diarrhoea, and on one occasion when she visited she could not find a nurse to help clean her mother. *"... There was not a nurse around, there was not a doctor around. I looked for so long, it was a good half an hour, and there was nobody anywhere. So in the end, I got some rubber gloves and I started to clean my Mum myself. At that point one of the nurses said: your Mum is highly contagious and you should not be cleaning her. I said: where are you; I need some help here, I can't leave my Mum sitting in her own faeces in a ward with visitors and everybody watching her."*

She also raised concerns about cleanliness. Her mother's bloodstained swabs were often left on the cabinet beside her bed or were dropped onto the floor. On one occasion, she left a bloodstained swab on the floor to see how long it remained there. It was left for three days before she decided to remove it herself.

The consultant told the family that their mother was in remission from bone cancer and that nutrition was important to improve her strength and, in particular, she should consume red meat. The next day, the daughter followed these instructions and ordered cottage pie for her mother's lunch, but when lunch arrived it consisted of a cheese salad. The auxiliary nurse was adamant that this had been ordered and refused to change it even though it was not suitable.

On one occasion, the patient's foot became tangled in the sheets at the bottom of the bed and was stuck in that position all night because she could not get the attention of the nurses. The family recently found out, from reading the medical records, that their mother also suffered fractured ribs while in Stafford Hospital. This information was never shared with the patient or her family. She recalled her mother complaining of pain in that region and at the time staff suggested it was psychological.

The night before her mother passed away, the family were told that it may be several days before she died. Because of this the family went home at 10pm but were called back to the hospital at 2.30am. By then it was too late and when they arrived 20 minutes later their mother had passed away. This was heartbreaking for the family. Despite nurses informing the family that they were with their mother, holding her hand when she passed away, her daughter fears that her mother died alone and was found by nurses some time later because no time of death was recorded.

She told me that she sat with her mother after her death but was keen to get her mother out of the hospital, so she agreed for her mother to be moved to the chapel of rest. However, after her mother was moved the family were informed that they would not be able spend time with her as the hospital had advised that she was highly infectious and had to be buried in a sealed body bag. Their last sight of their mother was seeing her head sticking out of a body bag. They were later told that this form of isolation had been unnecessary.

The daughter of this 67-year-old woman finished her written correspondence to me with the following words: *"My mum was my soul mate and my best friend, she was the kindest gentlest woman you could ever meet who spent her life looking after and caring for others, I was so proud that she was my mum. I am very blessed to have had the best parents anyone could wish for. My mum died aged 67 in a hospital that had forgotten its duty of care, patients were an inconvenience and it continues to happen to this day."*

She concluded her evidence to me by saying: *"my mum deserved better than that. She would always have deserved better than that. And if me having to do this and endure this stops one other person having to go through this in an NHS hospital, then my mum will not have died in vain."*

Section G
Mortality statistics

Introduction

1. In its report, the Healthcare Commission (HCC)[83] drew attention to mortality statistics which in part triggered its investigation. The HCC was dissatisfied with the response of the Trust to a number of mortality alerts and to the concerns it had raised about these. The report contains trenchant criticism of the Trust's approach concerning mortality rates and its reliance on an argument that these were attributable to coding deficiencies. Following publication of the HCC report, suggestions that there had been between 400 and 1,200 avoidable or unnecessary deaths appeared regularly in the media. An early example of a newspaper report stated:

   It is not clear how many patients died as a direct result of the failures, but the HCC found that mortality rates in emergency care were between 27 per cent and 45 per cent higher than would be expected, equating to between 400 and 1,200 'excess' deaths.[84]

2. Other reports have been more emphatic:

   The health secretary, Alan Johnson, today apologised on behalf of the government for the "totally unacceptable" failures by the Mid Staffordshire NHS trust's accident and emergency services which led to hundreds of unnecessary deaths.[85]

   About 400 more people died at Stafford Hospital between 2005 and 2008 than would be expected, the Healthcare Commission said.[86]

3. In Cure the NHS's opening statement to me, they referred to *"between 400 and 1,200 needless and unnecessary deaths"*.

4. Figures for 'excess' deaths do not appear in the HCC report as such. Understandably, I have heard great anxiety expressed by and on behalf of bereaved families who experienced poor care, as to whether any particular death can be attributed to the quality of care at the hospital. As a result, Cure the NHS have suggested that I examine each and every death occurring in the period under review to determine whether or not it was caused by a lapse in care. Equally, former directors have told me of their anguish at what they see as an effect of the HCC report:

[83] For ease, Healthcare Commission (HCC) is used in this chapter, not the Care Quality Commission (CQC), given the discussion refers to the activities of the HCC between January 2005 and March 2009. Healthcare Commission (March 2009) *Investigation into Mid Staffordshire NHS Foundation Trust*

[84] Rebecca Smith (Medical Editor) (18 March 2009) 'NHS targets "may have led to 1,200 deaths" in Mid-Staffordshire', *Daily Telegraph*

[85] Peter Walker (17 March 2009) 'Alan Johnson moves to "close this regrettable chapter in hospital's past"', *Guardian*

[86] BBC News (17 March 2009) http://news.bbc.co.uk/1/hi/england/staffordshire/7948293.stm

MR HINDLEY: *The general point about our reaction to the receipt of the Health Care Commission report. I take this very, very personally. Any suggestion that I and/or my colleagues stood by whilst we unnecessarily killed 30 people per month, one per day, without doing anything about it, I find totally offensive. Unfortunately that is what the man in the street now sees from this whole investigation, from the Health Care Commission and I suspect even this process, that we oversaw one death at least per day unnecessarily. I do not believe that is true or anywhere near the truth.*

DR WALL: *I am only sorry that the investigation of mortality figures is not in your terms of reference.*

MR HINDLEY: *It needs to be bottomed, does this matter. The truth of the matter needs to be established and until we do, I do not believe this whole issue in Staffordshire and the public reassurance that we are looking for, they won't get that assurance.*

MR BELL: *I agree.*

Q: *I think you all agree with that.*

DR WALL: *Absolutely.*

Q: *You think that is at the root of re-establishing trust between the local population and the hospital?*

MR HINDLEY: *The crux of the whole thing.*

5. I determined at an early stage that it would be quite impracticable to do as Cure the NHS had asked. It would have required individual consideration of every death of a patient in receipt of emergency care during the period under review. The HCC suggests a figure of approximately 1,000 deaths among non-elective or emergency patients per year.[87] Even if every such death were examined, with the help of relevant medical experts, it is highly unlikely that a satisfactory conclusion would be possible in many cases. There was often no post-mortem examination, and in many cases it would be quite impossible to say whether, for example, poor nursing care had contributed to the death. I took the view that the appropriate forum for families who wanted to seek the answers to this question would be at the Independent Case Notes Review (ICR) being run by the PCT. To impose an investigation on families that did not want one would be an unwarranted invasion of their privacy and could cause much needless distress.

6. Nonetheless, I quite accept that the notion of there having been a large number of 'avoidable' or 'unnecessary' deaths is a worrying one, and therefore I undertook to make some form of examination of the statistics, and to look at the interpretation of those statistics, to see if any light could be shed on their meaning, and whether

[87] HCC (March 2009) report Appendix E, Tables 5 and 9

any further lessons could be learned from this exercise. I have been greatly assisted in this part of the Inquiry by Dr David Shahian and Professor Sharon-Lise Normand, whom I invited to consider the HCC report and other information about mortality rates. In view of concerns expressed to me as to the independence of some of the protagonists in the debate over the significance of the figures in this country, I thought it would be helpful to obtain assistance from experts from outside this country. Their report appears in Appendix 7.[88] I am also grateful to Professor Sir Brian Jarman, head of the Dr Foster Unit at Imperial College School of Medicine, London, who, with the assistance of the legal representatives of Cure the NHS, provided a wealth of useful information both in writing and at a meeting.

Sources of mortality data

7. The raw data concerning deaths in hospitals is provided by all NHS hospitals on a monthly basis via the Patients Administration System to the Hospital Episode Statistics. This is now run as part of the Secondary Uses Service (SUS) by the NHS Information Centre for Health and Social Care, now known as the Information Centre, which is an NHS special authority.[89] At this stage the data is 'cleaned', removing obvious data input errors and omissions, preparing fields for analysis, etc.

8. The Hospital Standardised Mortality Ratios [HSMR] is an analysis of data drawn from SUS by the Dr Foster Unit at Imperial College. I am grateful to Dr Wall for the definition of HSMR that he offered: *"a comparison of the observed number of deaths in a particular hospital with the number of deaths that might be expected, having taken into account risk factors, such as age, diagnoses and the presence of other diseases (ie, the hospital's case mix). The expected number of deaths is calculated from national level data and the HSMR is a measure of risk relative to this national 'average'."*

9. As well as heading the Dr Foster Unit, Professor Jarman is a clinician specialising in medical statistics. He has been a member of the DH's Advisory Committee on Resource Allocation for many years, and was a panel member of the Bristol Royal Infirmary Inquiry chaired by Professor Sir Ian Kennedy. The Unit also issues monthly mortality alerts for 43 diagnoses and 79 procedures where the chances of death are double that which would be expected statistically. Where such an alert is triggered, a confidential letter is sent to the Chief Executive of the hospital concerned and to the Care Quality Commission (CQC), as happened at Mid Staffordshire in 2007 and 2008.[90]

[88] See Appendix 7 – Shahian/Normand (2009) Mortality Statistics Report
[89] More information can be found about the service at www.connectingforhealth.nhs.uk
[90] HCC (March 2009) report Appendix E, Table 4

10. Dr Foster Intelligence is not to be confused with Sir Brian's Dr Foster Unit. It is an entirely separate organisation which is run on a commercial basis, supervised by the Dr Foster Ethics Committee. It contributes to the funding of the Dr Foster Unit, which also has multiple other forms of funding. No member of the Unit receives any direct payment from or has shares in Dr Foster Intelligence. Dr Foster Intelligence describes itself as:[91]

    ... a public–private partnership launched in February 2006 that aims to improve the quality and efficiency of health and social care through better use of information.

11. It also describes itself as a partnership between the NHS Information Centre for Health and Social Care and Dr Foster Holdings LLP. It was founded in 2000 and is still chaired by Mr Tim Kelsey, a journalist by background. Its activities include the provision of real-time data to NHS trusts who agree to fund this and the preparation and publication of information for the public, such as its annual *Hospital Guide*. The guide ranks hospitals in accordance with a number of criteria, including mortality, and provides online information about the performance of each hospital against those criteria. It also provides a feed of information, including alerts, to its client trusts.

12. The HCC uses its own surveillance data to compute Standardised Mortality Ratios (SMR) from the Hospital Episode Statistics. It also looks at Crude Mortality Rates (CMR).

How is the HSMR calculated?

13. Each hospital admission is 'coded', that is, a record is made of the information that has been determined in advance as necessary for statistical, administrative and financial purposes. This information includes a record of the primary diagnosis based on the first episode of care, entered as a code based on the internationally recognised International Classification of Diseases version 10. At Stafford hospital, clinicians or nurses ticked a box on a form within the medical record, which was then turned into a code by the administrative employees in the hospital's coding department.

[91] See its website: www.drfosterintelligence.co.uk

14. The Dr Foster Unit takes the code for what Professor Jarman described as the *"first non-vague"* diagnosis, as the indicator of the cause of death. It then takes the figures for the diagnosis groups which account for 80% of deaths nationally. It takes the view that the remaining 20% involve diagnostic groups which are too small to yield statistically significant data. The resulting figures are then subjected to a standardisation process so that a fair comparison can be made between hospitals by adjusting for a number of factors, which include the primary diagnosis, age, sex, co-morbidities, deprivation and method of admission. The data for all these factors is taken from codes entered by hospital employees in the manner described above.

15. Statistical processes are then applied so that a result of 100 for any hospital, or any diagnostic group within a hospital, means that mortality is exactly as expected when measured against comparators. A result higher than 100 indicates a higher than expected mortality rate, statistically, and a result lower than 100 indicates a lower than expected rate. The figures are revised on a monthly basis when trusts review and revise their data.

Standardised Mortality Ratios (SMR)

16. The methodology used by the HCC/CQC for calculating the SMR is described in the HCC report.[92] Although it is not entirely clear from that document, the HCC uses the same data set from the Hospital Episode Statistics as Dr Foster and therefore is similarly dependent on the original coding.

Crude Mortality Rates (CMR)

17. The HCC/CQC also looks at mortality rates which are not adjusted for case-mix factors and therefore do not reflect the gravity of patients' conditions. However, the resulting figures are not as dependent on coding accuracy as the HSMR and SMR.

18. As a succinct summary of the figures shown at various times leading up to the HCC report, I gratefully adopt an extract from a House of Commons paper:[93]

[92] HCC (March 2009) report pp. 154–159

[93] *Mortality Rates at Mid-Staffordshire NHS Foundation Trust*, Standard Not SN'/SG/5030, House of Commons Library (18 May 2009)

Figure 1

3 Statistics relating to Mid-Staffordshire NHS Foundation Trust

3.1 Prior cause for concern

Internal surveillance of HSMRs at mid-Staffordshire

HSMRs had been internally surveyed at mid-Staffordshire since early 2006, when the trust purchased the Dr. Foster real-time monitoring system. The output from the system was shown by the trust to the Healthcare Commission in the course of its investigation; it revealed that during 2007/08, the trust was alerted to significantly high mortality rates in ten emergency admission diagnosis groups. These are shown in the table below.

Diagnosis groups generating mortality warnings from mid-Staffordshire's real-time monitoring system (emergency admissions only)

Patient group	Deaths at mid-Staffordshire	Expected number of deaths	Relative risk ratio
Acute cerebrovascular disease	129	95.2	135.5
Other lower respiratory disease	17	9.6	177.6
Cancer of bronchus lung	36	23.9	150.6
Septicemia (except in labour)	46	26.8	171.4
Cancer of ovary	8	2.9	276.6
Intestinal infection	11	5	317.5
Cancer of rectum and anus	6	1.9	313.8
Other infections, including parasitic	2	0.2	1067.2
Peri-, endo- and myocarditis cardiomyopathy	2	0.2	1172.7
Sickle cell anaemia	1	0	n/a

Source: Healthcare Commission

External surveillance

Dr Foster
Dr Foster Intelligence identified mid-Staffordshire as having a significantly high overall HSMR (including both elective and emergency admissions) in its Hospital Guides.

- In the 2008 guide (based on 2006/07 data), its HSMR was **114** (eighth-worst performing acute trust)
- In the 2007 guide (based on 2005/06 data), its HSMR was **127** (second-worst performing acute trust)

Prior to the Healthcare Commission investigation, the centralised monitoring system also generated 'mortality outlier' alerts[3], shown in the table below.

Patient groups identified as mortality outliers by Dr Foster Intelligence

Group	Date
Operations on jejunum	Jul-07
Aortic, peripheral and visceral artery aneurysms	Aug-07
Peritonitis and intestinal abscess	Aug-07
Other circulatory disease	Nov-07

[3] These are analytically equivalent to a significantly high HSMR within a particular patient group

19. In addition, the HCC issued a number of alerts before the start of its investigation:

Figure 2

Group	Date
Diabetes	**Aug-07**
Epilepsy and convulsions	**Sep-07**
Aortic aneurysm repair	**Oct-07**

20. Further alerts were generated during the HCC investigation:

Figure 3

Group	Generated by	Date
Chronic renal failure	Dr Foster Unit	Jul-07
Non-transient stroke	HCC	Oct-08
Other non-viral infections	HCC	Oct-08
Pulmonary heart disease	Dr Foster Unit	Nov-08

21. The HCC calculated that the statistical likelihood of a trust generating this number of alerts in the period of one year was *"extremely low"*.[94]

22. The HCC also examined the data obtained by the Trust following its purchase of real-time information from Dr Foster Intelligence. For convenience, the table of mortality rates created from this information by the HCC[95] is reproduced below:

[94] HCC (March 2009) report, p. 22
[95] Ibid., p. 144

Figure 4

Table 5: Output from the trust's real-time monitoring system for non-elective admissions for 2007/08

Diagnosis group (discharge)	Spells	%	Deaths	%	Expected	%	Relative risk
All	8,826	100%	934	10.6%	807.4	9.2%	115.7
Abdominal pain	976	11.1%	0	0%	3.8	0.4%	*0*
Cardiac dysrhythmias	404	4.5%	1	0.3%	7.7	1.9%	*13*
Acute cerebrovascular disease	353	4%	129	36.8%	95.2	27.1%	135.5
Urinary tract infections	340	3.9%	6	1.8%	18.2	5.4%	*32.9*
Noninfectious gastroenteritis	315	3.6%	2	0.6%	7.4	2.4%	*26.9*
Other lower respiratory disease	120	1.4%	17	14.2%	9.6	8%	177.6
Cancer of bronchus lung	82	0.9%	36	43.9%	23.9	29.1%	150.6
Septicemia (except in labour)	72	0.8%	46	63.9%	26.8	37.3%	171.4
Cancer of ovary	20	0.2%	8	40%	2.9	14.5%	276.6
Intestinal infection	11	0.1%	5	45.5%	1.6	14.3%	317.5
Cancer of rectum and anus	10	0.1%	6	60%	1.9	19.1%	313.8
Other infections including parasitic	3	0%	2	66.7%	0.2	6.2%	1,067.2
Peri- endo- and myocarditis cardiomyopathy	2	0%	2	100%	0.2	8.5%	1,172.7
Sickle cell anaemia	1	0%	1	100%	0	1.1%	9,147.7

23. This showed significantly higher than expected mortality rates in ten areas. Again, the HCC calculated that the statistical likelihood of this being explicable as a chance event was extremely low.

24. Professor Jarman kindly provided the Inquiry with the HSMR figures for the Trust between 1996 and 2008 – for all deaths, not just emergency admissions. These are reproduced below, with the confidence intervals (CIs) shown, i.e. the range of figures within which there is a 95% probability that the result is not chance.

Figure 5

Figure 1: Observed minus expected deaths at Mid Staffordshire Hospital 1996/97 – 2007/08

						95% CIs around HSMR		95% CIs around observed deaths		95% CIs around obs-exp deaths	
Financial year	**Admissions**	**Observed deaths**	**Expected deaths**	**Observed – expected deaths**	**HSMR**	**High**	**Low**	**High**	**Low**	**High**	**Low**
1996/97	11,088	774	782	-8	99	106	92	831	720	48	-62
1997/98	10,954	765	702	63	109	117	101	821	712	119	10
1998/99	11,635	794	733	61	108	116	101	851	740	118	7
1999/2000	11,776	801	754	47	106	114	99	858	746	105	-7
2000/01	11,496	718	670	48	107	115	99	772	666	102	-4
2001/02	12,156	821	736	85	112	119	104	879	766	143	30
2002/03	12,398	794	674	120	118	126	110	851	740	177	66
2003/04	12,315	841	668	174	126	135	118	900	785	232	118
2004/05	13,781	882	766	116	115	123	108	942	825	176	59
2005/06	14,073	878	707	171	124	133	116	938	821	231	114
2006/07	16,569	870	683	187	127	136	119	930	813	247	130
2007/08	16,433	947	813	134	116	124	109	1,009	888	196	74
1996/07–2007/08	**154,674**	**9,885**	**8,688**	**1,197**	**114**	**116**	**112**	**10,082**	**9,691**	**1,394**	**1,003**

Base figures accurate as of 15 January 2009

Figure 2: Observed minus expected deaths at Mid Staffordshire Hospital 2005/06 – 2007/08

						95% CIs around HSMR		95% CIs around observed deaths		95% CIs around obs-exp deaths	
Financial year	**Admissions**	**Observed deaths**	**Expected deaths**	**Observed – expected deaths**	**HSMR**	**High**	**Low**	**High**	**Low**	**High**	**Low**
2005/06-2007/08	**47,075**	**2,695**	**2,203**	**492**	**112.3**	**127**	**118**	**2,799**	**2,594**	**595**	**391**

Base figures accurate as of 15 January 2009

25. From these results, Professor Jarman confirmed that the cumulative number of observed deaths, less the expected deaths between 1996/07 and 2007/08, was 1,197. Of that number, the total excess of observed over actual deaths between 2005/06 and 2007/08 was 492. (within a 95% CI of 391 to 595).

26. The HCC figures for the Trust's SMR for emergency admissions for the years 2005/06 to 2007/08 are reproduced below:[96]

Figure 6

Financial year	18 to 74	75+	All aged 18+
2005/06	Rate = 3.3% p = 0.02 National rate = 2.5%	Rate = 16.2% p = 0.01 National rate = 12.7%	Rate = 7.8% p = 0.02 National rate = 5.7%
2006/07	Rate = 3.5% p = 0.003 National rate = 2.3%	Rate = 16.2% p = 0.004 National rate = 12.3%	Rate = 8.0% p = 0.005 National rate = 5.5%
2007/08	Rate = 3.5% p = 0.001 National rate = 2.3%	Rate = 16.0% p = 0.002 National rate = 11.9%	Rate = 8.1% p = 0.002 National rate = 5.3%

Source: Hospital Episode Statistics
National rate is for all non-specialist acute trusts in England

Overall effect of statistics

27. It will have been seen that on virtually every measure, the Trust's results were statistically significantly higher than expected. It had a higher number of alerts, and its HMSR and SMR results were significantly high. Even the crude mortality rates were consistently high.

The Healthcare Commission's presentation of their mortality rate findings

28. The statistical annex to the HCC report lists the alerts triggered by the Dr Foster Unit and the Commission's monitoring. It expresses observed and expected deaths as a relative risk for different diagnosis groups, provided by the Trust from the Dr Foster Intelligence real-time monitoring system.

[96] HCC (March 2009) report, p. 149

29. All the other data tabulated in the report arises from the Commission's own analysis of Hospital Episodes Statistics. It illustrates standardised in-hospital mortality ratios in graphical and numerical form, including by healthcare resource group (HRG). It shows crude (non-standardised) in-hospital mortality rates and compares these by age over time, between specialties and with national and peer group rates. It lists HRGs according to whether the 30-day mortality rates were better or worse than expected. The text describes the findings of these tables and the techniques used.

30. The chapter 'Outcomes for patients and mortality rates' describes the sources and background to the work on mortality. It stresses the importance of accurate and timely data and the role of clinical coding, as well as the limitations of the data and the challenges of applying quality control methods to healthcare. In particular, it acknowledges that alerts may be due to errors in the data or insufficient case-mix adjustment, requiring further analysis before considering whether there might be issues around quality of care.

31. For a number of measures, the HCC asserted that there was a very low probability that the high mortality rates arose from random variation. Whilst such variation might affect individual measures, it was very unlikely to lead to the number and consistency of high values observed.

32. It is to be noted that nowhere in the published report did the HCC assert that the figures they presented could or should be translated into a number of 'excess deaths'. I have established from inquiries made of CQC that its predecessor took a deliberate decision to remove from a draft of the report a cumulative figure for 'observed-expected deaths' of 800. The reasoning behind this was that it was feared this would be misleading.

33. This approach is endorsed by Professor Jarman, and I quote from his statement to the Inquiry:

I am aware that a loose figure of 400≤1,200 excess deaths [at the Trust] has been put forward by a number of parties. So far as I am aware this figure was originally proposed in the draft Healthcare Commission Report into Mid-Staffordshire Foundation Trust, but was omitted from the final report. These figures do not reflect the Dr Foster Unit's work, nor do I know what these figures are meant to represent or what methodology was used to derive them.

We recognize that mortality alerts and HSMRs cannot be used as a direct tool for discovering failings in hospitals. What the data do[es] do... is pose the question what is the explanation for our high mortality for the particular diagnosis or procedure that has alerted that month? We make it very clear in the alert letter that we send to the Trusts that we draw no conclusions as to what lies behind the figures.

34. Professor Jarman told me that, in fact, over half the mortality alerts are explained by hospitals as resulting for data problems such as coding errors. This is accepted to be the answer in some cases, but, as he pointed out, the HCC did not accept this explanation from the Trust. He also made it clear that:

Within HSMR it is not possible to give an exact figure for the number of unnecessary or excess deaths but one can give a figure for the number by which the actual observed deaths exceeds the expected deaths and give 95% confidence intervals for this figure. It would be impossible to statistically calculate the precise number of deaths that were unnecessary, or to statistically pinpoint which particular incidents were avoidable. That, if it were possible, would require careful consideration of the case notes for individual mortalities themselves. The data only indicates, and can only indicate, the number beyond that which would be expected of a hospital with the case mix, admissions, demographics and other features that a hospital presents.

35. Professor Hutton, one of my specialist advisers, in effect agreed with this. He advised me that the issue of excess deaths was a paradox in that it caused attention to be drawn to the Trust but could not assist in the assessment of individual cases. He considered that it was not possible to put an accurate figure on the true number. Indeed, he pointed out that, although it was highly unlikely, there was still a chance that the excess deaths recorded were a statistical anomaly and not part of an underlying trend.

36. Dr Shahian and Professor Normand also agreed. They remarked:

It is unfortunate that the figure of 400≤1,200 excess deaths became so widely publicized and sensationalized. These estimates are derived from 95% confidence intervals around the SMRs, and the intention was to redact them from the final report[97] *because of concerns that the public would not understand them. Perhaps a more thorough public educational effort describing the interpretation and limitations of these calculations would have mitigated some of the sensationalism that was subsequently observed. We do not have access to the calculations upon which these estimates are based, nor do we have any reason to disbelieve them. Whilst absolute numbers may vary slightly depending on what particular statistical technique is utilized, it is clear that the entire 95% range of excess deaths lies well above zero and mandated further investigation.*

[97] In fact it appears to have been a figure of 800, not the range of 400–1,200, which appeared in a draft, but this difference does not affect the experts' conclusion.

Coding

37. The reaction of the Trust, as reported by the HCC, was to dismiss the figures as due to coding errors and practice. This was borne out by the evidence I received. I heard from six witnesses across the range of non-executive directors, governors, managers, and clinicians, who all said the Trust's view was that coding would explain the high HSMR of 127 reported by Doctor Foster in April 2007. For example, the one medically qualified non-executive director, Dr Wall, told me:

    ... when we asked for an explanation from the executive directors, there was a proper investigation and we were told that they felt that the answer was coding at that time. It certainly was consistent with what we knew about the system.

38. Another non-executive director, Mr Bell, said:

    It was almost impossible to interpret from the data that those mortality figures were due to poor clinical care and that they were more likely to be due to coding.

39. Dr Wall also told me that the Trust had purchased the Dr Foster Intelligence real-time monitoring system in early 2006 because it had previously had little mortality surveillance.

40. The methodology of the Dr Foster Unit was also questioned in a report from the Unit of Public Health, Epidemiology and Biostatistics at the University of Birmingham.[98] The report claimed that there was evidence of a difficulty with coding when four hospitals were examined, and that the methodology was unsafe due to the constant risk fallacy. The contention, if I understand it correctly, is that the Trust had a low level of coding of secondary diagnoses. If this occurred it would make a case look less serious than it really was, and as a result the expectation of death in that case would be reduced. Professor Jarman vigorously disputes that these contentions invalidate the methodology, and there has been a lively correspondence as a result. One of the points made is that the Birmingham paper was funded by the strategic health authority. Professor Jarman told me that the steering group for the review included two members of the strategic health authority staff and two from the Trust.

41. Whatever the outcome of the academic debate, some witnesses from the Trust were not, in any event, prepared to see coding as a total answer. A consultant with a particular interest in this topic, but who was not a consultant during the period under review, told me with the benefit of hindsight:

[98] Mohammed and Lilford,(June 2008) Probing Variations in Hospital Standardised Ratios in the West Midlands. See also Mohammed et al. (2009) 'Evidence of Methodological Bias in Hospital Standardised Mortality Ratios: Retrospective database study of English hospitals', BMJ :228; 780

I think initially it was a kneejerk reaction but I was not there when this bit came up. This is all stuff I have been told afterwards. The Trust then looked at its coding. I do not know when the retrospective audit of the coding was done and they found that they were coding approximately 25 per cent of people incorrectly. The Trust made that argument around our HSMR is high because our coding is poor. I think it is fair to say the Trust lost the argument and the Healthcare Commission didn't feel that that was entirely the case.

42. While he objected to the figures of 400–1,200 being quoted, and he did think that coding provided a partial explanation for the HSMR, the consultant was emphatic that it was not the whole of the story:

    Q: *So whilst the figures that are bandied around as you say, I think ranging from 400 to 1,200, may not be – it is a huge range in an event – may not be reliable; nevertheless it indicates that there was a serious problem, doesn't it?*

    A: *There were serious problems.*

    Q: *Which would have resulted in unnecessary deaths.*

    A: *I would actually agree with that entirely. I think it is the magnitude of it.*

43. He thought that there was a danger in the coding argument:

    One of the problems was that as an organisation, there was a belief that it was largely coding. Whether or not that is true is a separate issue, but there was a belief that it was largely coding. I suspect that to a certain extent, that leads to a degree of complacency.

44. The search for a coding explanation was not the only avenue taken by the Trust. A mortality review group was set up in July 2007 to look at what the mortality statistics implied about clinical practice. Dr Suarez, former Medical Director, said that:

    ... we didn't have any formal mortality group reviews or hadn't had in the Trust up until that point.

    We were having two arms to this [response to HSMR]... [one] *in terms of numbers.... And on the other arm there was the clinical concern: did we have a problem, if so where was it and could we identify it?*

45. There is, unfortunately, no evidence that they did identify the problem.

46. Dr Shahian and Professor Normand have examined the debate that has occurred on the coding issues. They take the view that although coding issues may have had an impact on the figures:

    It is unlikely that this phenomenon completely explains the increased risk-standarized mortality at Mid-Staffordshire. Furthermore, the maintenance, certification and submission of accurately recorded data to the regulatory authorities are ultimately the responsibility of Trust leadership.

47. The experts have considered in critical detail the issues raised in the Birmingham paper and conclude that none of them, even if valid theoretical matters for consideration, justifies the conclusion that the figures do not implicate the quality of care. They are *"disturbed"* by the paper's conclusion that:

    quality of care should remain innocent until proved guilty.

48. They say:

    This is a hospital-centric admonition, but certainly not one that would be acceptable to most patients or to the regulators entrusted with ensuring the quality of their care. We accept that there is no single, perfect mechanism for assessing health care quality. We also agree that every statistical quality monitoring algorithm, including Dr Foster, should be critically examined by experts to determine its validity. However, we believe that in the case of Mid-Staffordshire, there were so many different warning flags from different entities, using different approaches, and over multiple time periods, that it would have been completely irresponsible not to aggressively investigate further.

49. In the end, they categorise this review as a *"distraction"*, although probably well intentioned.

50. The latest figures for Mid Staffordshire show an astonishing apparent recovery. The HSMR from the Dr Foster Unit for 2008/09 was 89.6.[99] In the *Good Hospital Guide 2009*, produced by Dr Foster Intelligence, the hospital is now in the top band as one of the top 14 hospitals with a patient safety score of 93.84 against the top performer (100) and the lowest of 0.00. This is, of course, a different measure than mortality, though the patient safety score does include it. The figures were announced during the period when the Inquiry was holding oral hearings in Stafford and were touched on by witnesses at the Inquiry. Mr Sumara told me that:

I think there are four elements in why Dr Foster is different... which I have no evidence for and I can't give you any detail. One is that the coding is just better now. The second one is we don't do strokes any more. The third one is we don't do MIs [myocardial infarctions] any more and the fourth one is actually because we have improved that emergency care pathway, your chances are you will get to see the right doctor quickly if you are medically ill. I think that will make a big difference to outcomes eventually. But I have got no evidence to say that has done the trick. In many ways do I care because all I am interested in is can I get it right every time? It is a bit of reassurance.

51. Sir Stephen Moss added that:

The assurance we now get is that the systems for monitoring this are very much tighter than they have ever been, and so now we are able to answer the sort of questions that you have asked, whereas I guess a year ago, there would have been a struggle to do that.

52. The comments display a recognition that monitoring and figures may provide some corroboration for standards of care but are no substitute for knowing about the actual quality of care delivered. This balanced, questioning approach is strikingly different from the one the Trust demonstrated when the Healthcare Commission approached it in 2007.

53. One consultant at the Trust expressed a more sceptical tone:

I think what has happened in the last couple of weeks... where some Trusts... who were last year in the top ten for the best performing Trust are now in the bottom ten for the best performing Trusts: this is an astonishing change in one year using the same methodology.

[99] Dr Foster Unit, Imperial College for 1 May 2008 to 30 April 2009, from the NHS Choices website, www.nhs.uk/pages

54. Dr Shahian and Professor Normand were not asked specifically to comment on the most recent figures, but they pointed out that:

Hospitals should recognize that not being classified as an outlier is no reason for complacency. All hospitals should constantly strive to improve their own performance, regardless of their current level of performance relative to other programs.

Comments

55. There is a clear preponderance of opinion that, whether or not coding practices at the Trust were weak, all the statistics taken together indicate strongly that mortality was higher than expected and that a search should be made for the reason. While it was not unreasonable to review coding, this was no reason not to look searchingly as a matter of urgency at the standards of care being provided in all areas where the figures were high. As Dr Shahian and Professor Normand point out, organisations are responsible for the accuracy of the data they supply to regulators, and should not only commit sufficient resources to coding and audit to enable figures to be accurate, but they should accept *"without excuse or denial the results of external analyses based upon data whose release they authorized"*.

56. Based on the evidence I have heard, it appears that there were efforts to look at this sort of issue via a mortality group. That this did not succeed in unearthing the serious issues that we now know existed is not entirely surprising. This was not a Trust with a culture of self-criticism, nor an openness to the possibility that there was an urgent need for improvements; mortality and morbidity reviews were not common. It was not an organisation which, as would be expected as a proper standard by Dr Shahian and Professor Normand, was reporting the results of performance assessments upwards through the organisation, including *"comprehensive and transparent presentations to the Board"*.

57. It is not within the remit of this Inquiry to adjudicate on the academic debate engendered by the work at Birmingham University, although the views submitted to this Inquiry may help inform that debate. The authors at Birmingham University were not asked to contribute to this Inquiry nor to comment on the views expressed in response to it, and therefore it would be unfair to do so.

58. What is firmly established based on the evidence I have seen is that the various mortality statistics were sufficiently significant to require an in-depth investigation of the areas of service apparently involved. Neither coding nor any of the other factors raised by the Birmingham group were sufficient explanation and should not have been regarded as such. However, it is in my view misleading and a potential misuse of the figures to extrapolate from them a conclusion that any particular number, or range of numbers, of deaths were caused or contributed to by inadequate care. Therefore, it is understandable that the HCC did not include such a figure in its report.

59. The development and publication of comprehensive, reliable and clearly understood, statistically based information about the performance of hospitals is clearly vital not only to the NHS to assist in the management and provision of high quality health service, but also to enable the public to judge for themselves the standard of performance achieved, to inform their own healthcare choices and to enable them to monitor the performance of an important public service. It is therefore particularly important that such information should be available from unimpeachably independent and reliable sources, and that it should be accompanied by clear explanations of what any figures mean, and, just as importantly, what they do not mean.

60. The contribution made in this field by Professor Jarman's Unit and Dr Foster Intelligence is considerable, but in my view there are matters which require review in terms of what information is provided and how it is provided.

- Firstly, it seems essential that a consensus view should be reached if possible, on the reliability and limitations, if any, of the methodologies being used. The controversy about coding, for example, is unhelpful to the public understanding, and potentially damaging if it leads managers into a complacent retreat, seeing it as a reason for inaction.
- Secondly, the use of statistics by Dr Foster Intelligence in its *Guide*, and the 'league' table that it includes, have an understandably powerful effect on the public. To the extent that this information reflects genuine good practice and identifies undoubted poor practice, it is to be welcomed, and if it results in the almost instant departure of senior executives, as has happened recently, that is perhaps a price worth paying. However, much scepticism has been expressed to this Inquiry about the apparent leap of the Trust in one year from the bottom of the 'league' to somewhere near the top. Many witnesses have recognised that this does not mean that all matters for concern have been removed – far from it. Therefore, there is a danger that the current information could create a misleadingly favourable impression of hospitals, including Stafford.

- Thirdly, whatever effect it may or may not have had on the Stafford figures, the variations that may occur through coding are potentially troubling. If different trusts adopt different practices with regard to, for instance, the depth of coding, it is difficult to see how this may not impact on the measured outcomes in a significant and misleading way. This is particularly the case when coding practices may be influenced by the fact that the codes are used to calculate funding. It is not clear to me what influence this may have on the process. There is surely a need to ensure that there is uniformity of practice throughout the country, so that the public can be assured that like is being compared with like.
- Fourthly, statistics are most respected and relied upon if they are produced by an impeccably independent and transparent source. No adverse inferences with regard to Dr Foster Intelligence are intended at all when I suggest that there may be a case for considering whether a public service should not be tasked with the production of this type of statistic. A public, generally accepted benchmark would surely be a useful resource both for patients and the NHS.

Section H
External organisations

Introduction

1. I now turn to the role of external organisations. Although not part of my Inquiry, I received evidence both orally and in writing from people who felt that the role of external organisations should be considered. This included extensive evidence from Cure the NHS.

2. Many people have asked why the various external agencies did not do more to put themselves in a position to realise that there was a problem and then to intervene. Within their evidence there is criticism of the robustness of the assessment process for foundation trust (FT) applications. These two issues are not the same, although they often became intertwined in the evidence.

3. I start with views about the lead primary care trust (PCT) and then consider in turn evidence about the strategic health authority (SHA), Monitor (both in general and in relation to FT applications), the Healthcare Commission (HCC – now the Care Quality Commission (CQC)), the Department of Health, and finally the role of the local authority's overview and scrutiny process.

The role of the primary care trust

4. Many comments were received about the lack of grip by the current PCT, formed in October 2006, and its predecessors on monitoring the performance of the Trust – before and after the Trust became an FT in February 2008.

5. In a written submission, Cure the NHS said that the performance reports considered by the PCT were insufficient:

   The PCT Performance Report, produced in October 2006, did not make any mention of quality of care. When a more comprehensive Integrated Performance Report was produced by the PCT in December 2006, it records no problems with the Trust, bar common problems of infection control across all the PCT's hospitals. There was no in-depth assessment of the Trust's wider performance beyond the compilation of the various different performance ratings the Trust had attained from the Self-Declaration and Healthcare Commission over the previous three years. There was no independent scrutiny of the Trust's performance, and no evidence at all of any PCT awareness of how the Trust was performing.

6. Cure the NHS expressed its belief that this situation improved little with the PCT's introduction in 2007 of integrated performance reports:

   The integrated performance report for January 2007 showed a worse performance from the Trust, highlighting the Trust's failure to meet treatment and infection control targets. Nonetheless, there appears to have been no efforts made by the PCT to go beyond the headline figures in its evaluation of the

Trust, and no direct action taken as a consequence of its failings. The integrated performance reports produced after this time, from May 2007 onwards, focused solely on headline targets and complaints indicators, without any detailed analysis of the quality of care provided.

7. A written submission from the Patients Association describes how until 2006 the quality agenda was considered by PCTs only in a limited way, because the main focus was on access and waiting time targets. In addition, reporting of complaints, as I have already noted, did not go to the Trust's Board between 2003 and 2006, but the PCT was not aware of this.

8. Other comments to the Inquiry raised concerns about the commissioning capacity of the PCT and its poor profile of involvement with the Trust. Views from staff describe an organisation that did not make a large impact on the hospital during this period. A nurse manager in emergency care stated the following:

   The PCT commissioning role does not make an impact. The admissions avoidance system they set up doesn't work.

9. One of the Trust's governors said that:

   ... the PCT is not effective.

10. In relation to the PCT, Sir George Alberti commented in his own report:

    It is also unfortunate that the main PCT commissioning services (South Staffordshire primary care trust) did not pay more attention to standards and quality of clinical care and comments from patients but focused more on throughput and targets.

11. In a written submission, the Shadow Secretary of State for Health, Andrew Lansley, refers to the 2009 report on the Trust by Dr David Colin-Thomé and the fact that improved practice-based commissioning by PCTs in 2006 did not translate into concern about the Trust or empower GPs as was intended. He notes that the report:

    ... simply accepts this failure... the failure of local commissioning procedures must be investigated thoroughly in order to provide assurance that local services will improve in the future.

12. In a letter to the Inquiry the College of Emergency Medicine gave evidence about the *"failure of commissioners"* and the Trust to invest in emergency services and to:

    ... appreciate the key role of the emergency department in providing prompt, safe and high quality care.

13. Several witnesses told me that they saw the need for better PCT engagement with local representatives and better assessment of information from patients and the public. A consultant with the clinical lead for acute care expressed the view that the PCT never seemed very supportive of Stafford Hospital, and it appeared to be a one-sided relationship.

14. Another consultant suggested that the relationship between the PCT and the Trust deterred some staff from coming forward with concerns:

    I actually suggested going public on several occasions and was discouraged by a series of medical managers [of the Trust] *along the lines: "you mustn't upset the PCT, we are working with them". And there was genuine concern that if the consultant body went to the PCT as a group and said: "look, you are allowing dangerous things to happen in your host hospital", then the Trust Board would have been disciplined.*

15. Several comments criticise the national reorganisation of PCTs in 2006/07, along with the resultant lack of capacity and organisational memory. The written submission from Cure the NHS said the following:

    ... the first function of a newly reconfigured organisation should be to take stock of the services that it was providing: to understand what it was commissioning and how well this was being delivered. This does not seem to have happened at the PCT.

The role of the strategic health authority

16. Comments about the SHA focus on a perceived lack of action and control of performance monitoring and assessment. These are allied to comments about the reorganisation of SHAs in 2002 and again in 2006/07, and the lack of organisational memory and capacity in SHAs and in their local health systems.

17. Cure the NHS gave its view as follows:

    The SHA, as with the PCT, was suffering from a loss of organisational memory following its creation in 2006. Nonetheless, it appears to have focused its attentions on its own organisational structure and its own aggrandisement at

the expense of ensuring that a rigorous audit was undertaken to overcome the gaps in its knowledge of the services that it was supposed to be regulating. The lack of a formal, comprehensive handover only strengthens the need for such an assessment and appraisal, yet this did not take place.

18. Cure the NHS added that the SHA readily allowed itself to be:

    ... reassured by the Trust that it was investigating mortality appropriately...

19. It added that the SHA wholeheartedly accepted a coding-based explanation for the Trust's high mortality rates.

20. Cure the NHS also drew attention to the meetings of the boards of the SHA and the prospective FT, saying the following:

    The outcome from the Board to Board challenge was a streamlined timescale and action plan to expedite the Trust's application. This was despite the clear findings from the Board to Board that the Trust had "many areas where there were gaps in control and accountability".

21. However, some staff witnesses did talk about the pressure from external organisations. One witness, the Chief Operating Officer, alluded to performance managers having an impact on the Trust by discussing the poor reflection on the Trust if it failed to meet a performance target:

    ... it would be performance managed via both the PCT and the SHA at the time against what was happening, why the required standard wasn't being met and what actions the organisation would take to improve and reach the required standard... and beyond that because from the Department of Health, there was a team within the Department of Health which likewise was looking at any outlier performance and would expect through the SHA an understanding of what was happening and why it wasn't being achieved – why improvements weren't being seen.

22. When asked whether the Trust was viewed by the SHA as being in need of close management, she said the following:

    It seemed to be nothing of particular note, of any particular concern, it was neither considered to be outstandingly good or anything of particular issue.

23. The former Chair of the Trust, Ms Brisby, said to me that she had been told by the previous SHA chair and others that the hospital was perceived as a *"failing trust"*. She went on to say that *"there was quite a lot of information saying this is a bit of a disaster area"*.

24. I received a number of comments about the part played by the SHA to drive the Trust's FT application through. Several people within the Trust said that the drive for FT status came from the SHA and that the Trust was under pressure to deliver on this. Mr Newsham, former Finance Director of the Trust, expressed that the main impetus came from the SHA, who were keen to have an FT on the patch and saw Mid Staffordshire as the best candidate.

25. The Medical Director at that time, Dr Gibson, said:

Certainly when we got three stars, it was a two-edged sword. It was very nice to have three stars and that was all very jolly, but there was a feeling our head was well above the parapet and I clearly remember a discussion with the then Chief Executive, who said: well, I have this letter here which makes it quite clear to me that I have to apply for foundation status.

The application for foundation trust status

26. Evidence and comments received on the Mid Staffordshire FT application process centred on Monitor, the organisation formed in January 2004 as the regulator of FTs, but comments also covered the roles played by the PCT, the SHA, the HCC and the Department of Health.

27. I received a submission from the Patients Association where they draw attention to the basics of the FT application process and the phases of involvement by the SHA, the Department of Health and Monitor. They note national guidance, which requires the SHA to confirm, among other things, that the Trust has:

... robust, comprehensive and effective risk management and performance management systems in place, which are proven to effect decision-making.

28. The national guidance also requires that there is no evidence of:

... issues, concerns, or reports from third parties.

29. The Department of Health's Applications Committee must review the assurances of the SHA and test them, and Monitor must:

... be confident and able to provide assurance to Parliament and a wide range of stakeholders that NHS foundation trusts will be legally constituted, financially sustainable, effectively governed and locally representative.

30. The Patients Association commented that the guidance:

... illustrates the layers of scrutiny the Trust was able to successfully bypass.

31. They say they now have:

... serious doubts about the robustness and probity of the foundation trust applications process because this Trust, now shown to be completely unsuitable for foundation trust status, was able to achieve it.

32. On the same theme, Cure the NHS submitted the view that the roles and responsibilities of the Department of Health, SHAs, PCTs, CQC and Monitor must be:

... addressed at a level of detail and stress tested, in the event of a marginal performance by an FT applicant or FT, [so] *that one can be sure that the system itself has no significant gaps, cracks or uncertainties. It may be that more than one stakeholder takes responsibility for certain activity, which can be just as confusing in such a complex environment.*

33. Andrew Lansley's submission contained the view that:

... it would be beneficial to examine the advice formulated by the Applications Committee in this instance, in order to ensure public confidence in the process.

34. I received several other comments on the flow of information and evidence between organisations in the FT application phase. It was suggested that it was clear that Monitor would focus their own inquiries on corporate governance and financial issues, and would work with other agencies on the service quality aspects of an application.

35. Mr Gill, the current Director of Finance of the Trust, who in previous employment had been involved in the preparation and assessment of trusts for FT status, described the involvement of those agencies:

Monitor would do two things really. One, it would do a press search to understand if there were local issues for organisation that it would need to pick up on, be it local, political, local issues around the strategy, closing of an A&E or moving services from one site to another and so on. Just to understand the local setting and the local interest. But then it would send out communications to the other regulators to say: this particular trust is coming up for assessment, do you have any evidence or any information that you wish to share with us? So it was very reliant on third-party evidence.

36. Ms Brisby, the former Chair of the Trust, told me about the start of the process with the SHA:

The SHA had the responsibility of carrying out the first diagnostic on whether trusts were fit to go to foundation trust status... where they came in and had a look at the Trust and asked us questions... I have to say we were absolutely dreadful, really answered the questions – got it wrong, answered the questions inadequately, misread what was expected of us.

37. Nevertheless the Trust *"scrambled through"* that part of the process, according to Ms Brisby.

38. In its submission, Cure the NHS wondered why Monitor did not pursue the service quality issues more vigorously at the application stage, since it was aware of a problem with the Dr Foster Intelligence data:

The cursory reference to it in the Board to Board meeting was insufficient to properly scrutinise a hospital with such a longstanding record of poor mortality statistics.

39. A former staff nurse and whistleblower expressed views about the impact upon targets during the period in which the hospital was making its application for FT status. She said that Monitor was visiting the hospital, and there was real pressure on not breaching the four-hour target (in A&E), so people were actively bullied and pressured into lying about timings. The view of a nurse manager in emergency care was that applying for FT status was the main cause of the Trust's problems.

40. However, other witnesses felt that the Monitor process was good for the development of the Trust. Mr Newsham, the former Finance Director, said that Monitor spent six weeks at the Trust and that the process was *"challenging, it was demanding, it was rigorous"*.

Monitor's role in assuring quality of care

41. The reliance of Monitor on other external agencies to feed its annual decisions about the ratings for quality of services to be given to established FTs was also the subject of comments. Witnesses perceived a failure by Monitor to gather its own clinical quality information and assurances and to make sure that other national agencies provide it with adequate and more integrated information.

42. Mr Gill said:

In terms of the effectiveness then, Monitor was very clear that it was staffed up to look at the financial and corporate governance aspects only of an organisation. The clinical quality and clinical effectiveness side of life was clearly the domain of the Healthcare Commission as the other regulator at that point...

43. A witness who was involved in preparing self-assessment returns at the Trust discussed the process:

Q: *To be clear about this, you say that that focused on process?*

A: *Yes.*

Q: *... would it be correct for us to understand that the Healthcare Commission's review in 2007 and the activities of Monitor were essentially related to establishing that the mechanisms were defined and routes and processes were in place?*

A: *Yes.*

Q: *... but neither of those bodies, I think, makes any demand for evidence that they are working?*

A: *Not in the outcome sense. That is – it is a gap because they don't look at outcomes. The Healthcare Commission –*

Q: *... my understanding is that they wouldn't, for instance, say 'can we see your log of the effectiveness of the process' whereby something has happened, it has gone through, there has been some decision made and the loop has been closed? I think that is absent, isn't it, from the assessment?*

A: *It is.*

44. In oral evidence the current Chief Executive, Mr Sumara, gave a view on quality assessment:

I am not aware of any external body, a regulator, that has that sort of capability, and certainly the foundation trust process wouldn't give you any assurance about the quality of patient care and safety. In fact I think Monitor are only now just trying to build up that expertise.

45. Some who gave evidence suggested that Monitor should be more proactive with each FT, and should improve and review its guidance to all FTs about governance of service quality. This is linked to evidence that trusts such as Mid Staffordshire have too readily taken external approval as confirmation of quality.

46. The former Chair's discussion in oral evidence is an illustration of this:

Q: *... you saw the fact that the Healthcare Commission had assessed you as being in a position to apply for foundation trust status as confirmation of the Trust providing a good or satisfactory standard of service?*

A: *Yes. I am absolutely certain that if we had got the sense that that was not the case and the Healthcare Commission had got it wrong, and actually we were providing a really poor standard of service, then that would have been a very different sort of discussion.*

47. She also said the following:

The clinical side of the Trust's activities and responsibility for determining whether that's up to standard or not, rests with a whole bunch of organisations, the most significant of which is the Healthcare Commission. So it is not as if we were saying our services are fine. It is more there is external assurance of the fact that you have reached the standard in terms of service provision.

48. Three non-executive directors, Mr Bell, Mr Hindley and Dr Wall, spoke about the mortality data in this context. Mr Bell said:

... there were certainly issues raised by the people who were auditing us for the foundation trust application. They raised issues about our dealing with the mortality issue. They went away and I believe spent quite a lot of time scrutinising the Trust's approach to that mortality data and went away satisfied... and certainly when we got to the board to board challenge, I am not sure mortality was even mentioned because we had obviously put their minds at rest.

49. Mr Hindley added:

I think we were by then well assured.

50. And Dr Wall confirmed:

We as a board took clinical issues, the whole issue of care very, very seriously... we got our assurances from a variety of sources, from internally within the Trust but also from external sources, from various external inspectorates, whatever. So we had inspections by the Royal Colleges, we had inspections by patient groups, we had inspections by... local authority scrutiny committee. We had inspections by the breast cancer screening team from the West Midlands and it was – they weren't all perfect by any means, but generally speaking the picture that was emerging was very positive.

51. Another non-executive director, Mr Carder, said of the mortality data issue:

The explanations that we were coming up with, the research from Birmingham University and all the work that was being done was being accepted by Monitor and the SHA, because frankly the position we were in in terms of the foundation trust status, Monitor was well aware of it, and I think if they had any concerns, they would not have granted us foundation trust status... In the period that we were being looked at, the feeling was that everybody and anybody was crawling all over us.

52. Mr Bell reflected on the Trust's contacts with external assurance processes:

I still to this day do not understand why we were not aware of these issues and I find it astonishing that nothing was said to us, that none of these investigating or scrutinising bodies found even a glimmer of evidence of these issues; that in our informal contacts with doctors and nurses around the hospital, that nobody ever said anything about these issues.

The role of the Care Quality Commission (formerly the Healthcare Commission)

53. Many witnesses have referred to the role of the HCC, its predecessor the Commission for Health Improvement and its successor CQC. Their comments focus largely on the lack of proactive assurance, or 'triangulation', of information, and about the perceived over-reliance on reporting and 'self-assessment' by trusts and other NHS organisations.

54. The written submission of Cure the NHS suggests that the willingness of the HCC to rely on those it is meant to be monitoring to adhere to the regulators' rules has consistently proved itself to be fundamentally flawed:

... the Self Declaration system has proven itself to be open to disingenuous completion, leading to Annual Health Checks that are left devoid of any meaningful and reliable outcome.

55. Cure the NHS's submission also draws attention to the inconsistent annual assessments of the Trust conducted between 2002 and 2008:

During this time the Trust's annual performance ratings fluctuated wildly.

56. The Trust's Director of Human Resources in the period 2000–06, Ms Sadler, noted that the award of the maximum three stars in 2004/05 had been a surprise to everyone.

57. The Medical Director during 2003–06, Dr Gibson, said the three-star award was *"a pressure"*, and a big part of the reason why the Trust *"had to apply for FT status"*.

58. The written submission from the Patients Association refers to HCC assessments of the Trust that failed to give an accurate picture of the care being provided. In the annual health check processes for 2005/06 and 2006/07 the Trust was rated by the HCC as having a *'fair'* quality of services and in the latter year the core standards were scored as being *'fully met'*. The Patients Association felt the following:

    This raises serious concerns over the assessments made by the HCC since its inception in 2004. According to the Healthcare Commission report, in the 2006 and 2007 national inpatients surveys, the Trust had been in the worst 20% on the question about whether there were enough nurses. A review in 2004/05 showed the Trust had a high overall number of complaints. The Trust was worst out of five local Trusts for the number of complaints about nursing care and the second worst out of 24 small Trusts outside London. In light of this, it is reasonable to ask how the Trust was able to achieve relatively positive ratings from the HCC.

59. A staff witness discussed self-reporting:

    Q: *So for 2007/08, the Trust itself was reporting that it was compliant with 42 out of 44 standards.*

    A: *Yes.*

    Q: *Do any of those standards relate to quality of care?*

    A: *I think they all link back to quality of care. All the standards do. However, the core standards and the lines of inquiry are very much about systems and processes that are in place, and the declaration itself.*

60. In addition to the self-assessment system, the HCC does undertake visits to some trusts. Cure the NHS gave evidence about the nature of these, feeling that they were not conducted as unannounced visits as had been intended. Referring to visits in 2008:

    For example, [a] *Lead Nurse... at the Trust, emailed other senior members of the Trust in March 2008 stating that the "HCC have announced we are on the list for an unannounced visit between April and June".*

61. Several people talked about the decision by the HCC to investigate the Trust in 2008, suggesting that this came later than it might have done. According to one consultant witness:

What I can't understand is with the HSMR [Hospital Standardised Mortality Ratio]... *of over 140 odd in 2004 and the HSMR falling from 2006 onwards, why they decided to investigate us in 2008. I think to me it just seems astonishing that CHI* [the Commission for Health Improvement] *had obviously had some concerns and that became the Healthcare Commission. I am just not really sure why, if things were as bad as they felt they were – they were even worse, if you believe Dr Foster's in 2004 – why did they wait four years to investigate us?*

62. On this theme, Cure the NHS said:

... the Dr Foster Intelligence real-time monitoring system produced ten mortality warnings for emergency admissions alone during 2007/08, and four patient groups were identified as "mortality outlier alerts" between July and November 2007. These were all forwarded not only to the Trust itself, but also to the Healthcare Commission.

The role of the Department of Health

63. A considerable amount of evidence and commentary reflected a dissatisfaction with the perceived lack of 'joined-up' monitoring and regulation at a national level. Some of this was directed at the Department of Health's own actions but much of it was calling for decisions by the Department to review external regulation systems.

64. In a letter to the inquiry William Cash MP said:

The NHS is a system and the system from Monitor to DH failed to spot the problems at Stafford as elsewhere over a long period.

65. He felt that the HCC identified clinical failings but stopped short of considering the role of other agencies, and the Colin-Thomé report did not look at Monitor or other regulators.

66. The submission of Cure the NHS says that the Trust's failings are:

... a striking indication of a wider, malfunctioning regulatory system. CTNHS note the failure of external bodies to whom the Trust were supposed to be accountable to perform the functions that were meant to be performing.

67. It also stated the following:

Whilst the failings of the Trust itself are manifold... [it] *is not an isolated organisation, insulated from external pressures and able to entirely determine its own objectives. It is umbilically tied to the regional PCTs and SHAs, is regulated by Monitor and (what is now) the Care Quality Commission, and has its ultimate direction set, top down, by the Department of Health. It is, therefore, impossible to analyse the failings of the Trust without examining the wider regulatory and commissioning framework which enabled, allowed, and tolerated the appalling care at the Trust to develop and survive.*

68. Several individuals and organisations have commented on the lack of clarity surrounding regulation and said that the system is confusing. In their evidence to the Inquiry many of the 'regulator' organisations commented about problems with the actions of other regulators.

69. In his submission, Mr Lansley expressed concern about unanswered questions, saying that someone:

... should pick up the Colin-Thomé report's recommendations that DH should describe regulators' roles and how they inter-relate and that all NHS bodies should have effective continuity planning as the norm.

... should pick up the failure of the local commissioners; not so far investigated as such.

... should look into why the SHA and NPSA [the National Patient Safety Agency] *did not pursue SUI* [serious untoward incident] *matters raised with/reported to them.*

... should analyse whether the NPSA did feed back to Staffs or more widely, as is its purpose.

70. He referred to the various national reorganisations of NHS structures and commissioning systems, saying that:

Neither the Healthcare Commission, Alberti or Colin-Thomé reports went on to investigate the Government's role or policies in imposing these reorganisations.

71. In its written submission the Patients Association lists a number of other bodies whose role it feels should be examined. These include the National Confidential Enquiry into Patient Outcome and Death, the Independent Complaints Advocacy Service, the Parliamentary and Health Service Ombudsman, the Health Protection Agency and the coroner.

72. I received a set of comments about the lack of any system requiring regular monitoring or approval visits by the various clinical Royal Colleges or the general medical and nursing councils.

73. In a letter to the Inquiry the Royal College of Obstetricians and Gynaecologists said that it had had no involvement in the Trust since its visit in 2002. Responsibility for visiting and approving hospitals for training passed in 2006 to the Postgraduate Medical Education Training Board.

74. In another letter, the Royal College of Physicians referred to representations it had made to the Health Select Committee about the loss of regular visits to trusts in the early 2000s. These were linked to medical training but *"were a valuable source of intelligence about clinical issues locally".* The letter also said that *"*[*the*] *Royal Colleges' professional networks are invaluable"* in cases falling between those resolved locally and those that are reported to regulators.

75. Royal Colleges do continue to operate an invited review system. The Royal College of Surgeons conducted reviews at the Trust in 2007 and 2009.

76. A number of witness submissions referred in passing to the role and profile of the NPSA, and witnesses felt that this was one of the agencies that could be more proactive and contribute better to the triangulation of evidence. In his submission, Andrew Lansley noted that serious incidents at the Trust were sometimes reported to the SHA and sometimes to the NPSA. He was concerned that:

    ... there has been no further investigation of whether the body tasked with alerting NHS organisations of risks to patient safety fed these reports back to the SHA, the DH or the Healthcare Commission. It is important to investiagte why the NPSA failed in its duty in Stafford in order to ensure public confidence in the capability of the national reporting and learning system to safeguard patients elsewhere.

77. Taking the national context overall, several witnesses noted that the problems in Mid Staffordshire came at a time when there was a developing momentum behind the FT programme; there were reorganisations of SHA and PCT boundaries and devolution of performance management from SHAs to PCTs; and 'control' of FTs was passing from SHAs to Monitor. People said that in many SHA and PCT organisations there was an almost total lack of organisational memory and that this environment and context must have had a bearing on the situation in Mid Staffordshire.

The role of the Overview and Scrutiny Committee

78. Moving beyond the NHS to consider the health overview and scrutiny role of local authorities, I received evidence from a number of people about the perceived ineffectiveness of that system in this case. Many comments were about the lack of understanding and grip on the real local healthcare issues.

79. I heard from a witness speaking for Cure the NHS:

> *So we have got all these bodies that are supposed to challenge, find out what's really going on. Julie took the issue to the Oversight and Scrutiny Committee* [OSC] *of Stafford Borough Council. It was just a pleasant little talking shop, and again there are plenty of minutes of that body and those presentations that Julie talked about, that were being swapped with the OSC and the hospital, even as the Healthcare Commission were writing in September 2008 to say: you are a dangerous place, get your A&E sorted out. Meanwhile, the management team is giving a slide show to the OSC saying: it is absolutely fine. The OSC went for lunch at the hospital, were shown round a little bit, asked no questions.*

80. Cure the NHS's submission says that the papers relating to OSC meetings show a lack of real interrogation and an over-willingness to accept explanations.

81. I have seen from documentation supplied by Staffordshire County Council that their OSC agendas contain little evidence that the OSC took a particularly aggressive or proactive approach to their scrutiny of the local NHS. Apart from a standing item for 'health trust updates' at its monthly meetings, the committee considered just six specific agenda items about the Trust during 2005–08. Of these, four items were about the Trust's FT application and strategic direction; one was about facilities in Cannock Chase Hospital; and one was about the HCC's investigation. The OSC also made comments each year about the self-assessed annual health check which each local trust did for the HCC. On one occasion they resolved to meet the Trust about areas of non-compliance.

82. Some functions are delegated to borough councils' OSCs. A letter to the Inquiry from Stafford Borough Council listed 21 occasions when its OSC had dealings with the Trust. Of these, eight were general progress and information sessions or hospital visits, four were related to the FT application and six were discussions of particular service issues including infection control. On three occasions the OSC discussed the Trust's staffing and financial problems – two in 2005 and one in 2008.

83. In contrast to the evidence about ineffective local authority scrutiny, the chair of the borough's OSC had the view that other regulators were less appropriate, saying:

There are too many people, too many organisations looking into the operations of the NHS. Most of them dance to the tune of the Department of Health. They are concerned not only with healthcare but the cost of healthcare... There is only one independent body which scrutinises the NHS, and that is the local authority overview and scrutiny committee, which does not concern itself at all with the cost of the provision of care.

Patient and public involvement forums

84. Comments relating to the patient and public involvement forums (PPIs) primarily focus on the way in which they were tightly controlled by strict rules and regulations, which meant that the members felt restricted in the way in which they could engage and participate effectively.

85. Age Concern South Staffordshire told the Inquiry that:

... forums came in and we got the contract, but after six months we were told they were going. It took the remaining three and a half years to kill them basically. I know that sounds a bit crude but actually that's exactly what happened.

86. Further, in relation to the way the PPI was funded and managed:

In those days we were under contract... one of the main reasons for changing the PPI was because it was done under contract to the Patient and Public Involvement in Health quango. Money was given from [the Department of] *health to the quango. We were then contracted to the quango and basically what we could do and what we couldn't do was very, very tightly controlled.*

87. I also heard about the failure of the PPI to identify concerns relating to Stafford Hospital. Not only was the structure somewhat restricting, but the members also failed to communicate effectively with each other:

... because of the structure of the forum, because of the way it was set up, clearly it was handed down about what you could do and what you couldn't do to forum members, and maybe felt very constraining... Under the new circumstances people perhaps would have felt more engaged with it but also could have said: "well, look, I think there is an issue here". I would freely admit that clearly – and I've discussed it with my colleagues... this morning – we never actually sat down, either the members of the LINk or the staff here, and actually said: "is there a problem? Is there are a problem here?"... I have only scratched the surface and I get emails from the staff saying: "Oh, it was a nightmare, it was a nightmare". But we never actually sat down – and I think we could have done more.

88. Age Concern went on to say that a failure to have a joined-up and inclusive approach contributed to the failure of the PPI to identify concerns.

... clearly there were issues that perhaps – but the problem is it was all disjointed and disjointed stories, but we never actually sat down, the PPI forum never actually met as members of staff... we kept them quite separately and we didn't do it deliberately. It was because it was a different bit of the business; we didn't really feel it was – the care operation was different from the engagement operation, I suppose.

89. On reflection, they recalled the following:

I didn't know that things were quite as bad as they were. There was certainly an issue around cleanliness, certainly an issue around C. diff and the other one.

90. With regard to the PPI's awareness of the high mortality rate at Stafford Hospital, they reported:

I've spoken to some forum members and they never saw those figures. They said they never saw them.

91. The PPI was being wound down with the ultimate intention of it being dissolved, and I have been informed that it became less functional and ultimately ceased to work, as members became less and less engaged with it.

Local Involvement Networks

92. Following the dissolution of PPIs, Local Involvement Networks (LINks) were introduced. Locally, the contract for providing this service was awarded to Staffordshire University, and there has been criticism surrounding this decision – primarily due to the university's perceived inexperience in providing such services.

93. In relation to the contract being given to Staffordshire University I have been told (by Age Concern South Staffordshire) that the university's failure to invest in staffing levels and its lack of experience had a detrimental impact in the running of the service:

They are an academic institution, and as far as I was aware had very little bottom links with voluntary organisations... Clearly they took a decision to appoint only a very few members of staff, at what I would perceive as ridiculous rates of pay... As a consequence, I think they have only two and a half members of staff... There are roles and responsibilities of volunteers and there are roles and responsibilities of paid members of staff... Volunteers, with the best will in the world, are not just – they need to be put within a framework. Everybody does... I genuinely think Staffs Uni didn't understand that. I think that's been the problem.

94. I have heard from present and former governors of the Trust that the LINk is no longer a functioning body. It is yet to be replaced by another service.

95. During the oral hearings in December 2009, I was told:

The county council took the decision about three weeks ago to terminate the present system, the present LINk. It had been in existence for 13 months and it hadn't produced a single health-related report. It hadn't functioned. To say it hadn't functioned well would be an exaggeration. It hadn't functioned at all... Although the constitution of the LINk does not specify that it should make its reports to the Overview and Scrutiny Committee – in fact it says they should be made to the Care Quality Commission – the link would be well advised to make its reports to the Overview and Scrutiny Committee so that, if necessary, a more prompt approach to the hospital and an enquiry could be made.

96. I also received written evidence from the Bishop of Stafford, who commented on the role of local community organisations more generally:

The disbandment of Community Health Councils (CHC) a few years ago, and their replacement with PPIs, LINKs, and governors, was a bad mistake. CHCs had a remit that extended across the purchaser/provider split, and sufficient clout to ensure they were listened to. The Government should be encouraged to bring them back. Meanwhile, local organisations as well as individuals can still get organised and get elected to the existing watchdogs and ensure that they make a positive contribution. It is highly desirable for members of such bodies to meet periodically on their own, i.e. without NHS personnel present, so as to plan and consider what questions to ask: otherwise they are all too easily liable to be overwhelmed by healthcare professionals swamping them with statistics.

97. He also stated the following:

Health is too important to be left to hospitals.

Foundation trust governors

98. I heard from a governor of the Trust in relation to the selection process for becoming an FT governor:

... the council of governors has a large component drawn from the staff of the hospital. And the elected governors are elected on a very, very small mandate... The hospital would serve a population of perhaps 350,000. Something under 3,000 people signed up to be members of the Trust. They were encouraged to do this by notices put up in GP surgeries and in the press. So that was 1 per cent. Of that 1 per cent, figures in the low hundreds were involved in the election of elected governors. So a very, very small mandate.

99. Another governor told me about the role and function of the council of governors:

Basically, we are meant to question the direction of the Trust, raise any concerns and represent obviously the – the public governors represent the views and the concerns of the public and the same for the staff in terms of representing the staff, but it is also about feeding back to those who have elected you about what is happening in the Trust. To be perfectly honest, it was a huge learning curve for everybody and I can't say that it was an effective body at all and when we gained foundation status, I don't think anybody, either the Trust or the council of governors, were really clear about their role or how to put it into play. As I say, it was a learning thing for everybody.

100. I also heard from a governor of the Trust who relayed her experience of the meeting structure imposed by Monitor:

We had pages and pages of what we were supposed to do, but I have to confess, I thought it was only just me that didn't understand a word. But it wasn't just me at all. I think this was Monitor's interpretation of what a governor should be. But in any event, whatever it was that I understood Monitor, whoever it was said we should be, it certainly wasn't happening practically in the meetings... We were controlled... if we had to put any other business, it had to be two weeks before so nobody ever did. We always got the minutes of the meeting and the agenda like three days before a meeting. Nobody was encouraged or indeed dared to ask a question.

101. She went on to tell me that concerns such as high mortality rates at the hospital were not discussed openly in meetings and the governors were made to feel as though they should not ask questions or challenge the information provided to them:

Q: *So in relation to mortality rates, for example, what you were being told – that the problem was a coding problem?*

A: *Oh, utterly, and when I did ask at one meeting when I was feeling particularly brave or stupid, how this worked, we were told it is very complicated. Everything was always very complicated. And I thought: well, what system can be so complicated that it doesn't work?*

102. I heard from another governor who told me of the restricted powers of the council of governors:

The next problem at the council of governors was that the constitution which was adopted, which was a model constitution provided by Monitor, was very restrictive and was interpreted by the then Chairman and Chief Executive to be

that the role of the governor was to be an ambassador for the Trust out to the population. In other words, putting it bluntly, part of the hospital's PR operation. I didn't see it that way. One or two others didn't see it that way either.

103. FT governors have an important part to play in the oversight of an FT. In this case, they had little chance to function effectively before the HCC's investigation began. The Chair of the FT also chairs the Board of Governors. This role gives the FT Chair practical control over the governors' agenda and may make it more difficult for fellow governors to raise and pursue matters of concern.

Comments

104. In his closing submissison to the Inquiry Mr Havers, on behalf of Cure the NHS, drew attention to a range of external bodies:

How did the Trust obtain a three-star rating by the Commission for Health Improvement at the same time as its provision of care was so substandard and its mortality rates, it seems, so high. How did it achieve foundation trust status in June 2007 in the light of those factors? Are the criteria used for the approval of foundation trusts appropriate? Do they adequately focus on the quality of patient care? Are Monitor's powers and criteria in relation to the regulation of foundation trusts effective and appropriate? Do they encourage insufficient focus on the quality of patient care? Why did Monitor not take action sooner? They were aware of the higher than average mortality rates from as early as 2007. And were their actions, when taken, sufficient? Why did they not take steps to remove the other directors from the Trust and some of its clinical staff? Why did the Healthcare Commission not take action sooner? They too were aware of the higher than average mortality rates from as early as 2007. Why did the SHA, the PCT or the Department of Health not take action sooner, and did the targets imposed by the Department of Health encourage an inappropriate neglect of the quality of patient care?

105. It is clear from evidence given to the inquiry that the public and the Trust's staff lack confidence in the ability of external organisations to effectively regulate and manage health services. It is clear there is more still to do to restore confidence. There is a widespread view that the system failed to detect and act upon the deficiencies of the Trust in a timely and effective manner. There is a genuine public concern that the present system of regulation cannot ensure that no such situations re-occur.

106. It is clear from this evidence that neither the reviews commissioned to date by the Government, nor this Inquiry, given its terms of reference, are capable of allaying those concerns.

PATIENT STORY

The wife of a 67-year-old man took the time to share with me, by letter, the experience of her and her husband at Stafford Hospital in 2006. She documented that her husband had suffered with long-term neurological problems and a disability, which affected his mobility. He also experienced numbness in his hands, which resulted in a lack of dexterity.

She recalled that, in early 2006, her husband began to feel unwell and was losing weight. He subsequently underwent a scan at Stafford Hospital which revealed that he had an inoperable tumour at the base of his spine, and his illness was deemed terminal.

On his admission to the emergency assessment unit, his wife recalled that he was not given a pillow, and for two days he had to use a rolled-up blanket instead. His wife was initially told that she could bring in pillows for her husband; however, when she did so the ward sister refused to allow him to use them. She later provided him with a single pillow which had been taken from another patient.

Nursing staff were made aware of her husband's mobility issues and difficulties with his hands on numerous occasions; however, his medication was continually placed on his locker or bedside table. Her husband was incapable of picking up the tablets and when he attempted to, his wife would find them on the floor. He was also unable to feed himself, yet there was nobody available to assist him. On one occasion, she arrived to find her husband attempting to eat cold scrambled egg with his fingers, because his cutlery had fallen to the floor.

She recalled that call bells were rarely answered and in any case were frequently placed out of the reach of patients. She documented that her husband *"soiled his bed time and time again because no-one had answered the call-buttons. On numerous occasions when I arrived on the ward, he was lying in faeces and several times he had been lying in it for so long that it dried and caked onto him. Time and time again I had to fetch the necessary equipment from the sluice and attend to him myself because there was no staff in evidence on the ward."*

She recalled that she regularly had to wash and shave her husband and attend to all his needs, because staff were rarely available. She felt that the staffing levels were insufficient to cope with the number of patients and the nature of their illnesses. During the entire 12 weeks that her husband spent at Stafford Hospital, he was only given one assisted shower and two bed baths.

She documented that she often arrived at the hospital to find her husband lying tangled in his bedding, unable to help himself. She was told that patients who needed the most attention had to be left until last because it took too long to deal with them. She also recalled that her husband needed to be catheterised; however, the catheter frequently became dislodged and he was subsequently left lying in pools of urine on the PVC mattress cover.

Her husband commenced chemotherapy, but he was not administered anti-sickness medication for three days following his chemotherapy session and he was continually nauseous and unable to eat. While he was written up to receive it, his wife had to ask for it to be given on four separate occasions before it was administered.

When her husband was transported to and from Cannock Chase Hospital for chemotherapy, the doctor said that he must be transported on a bed to ensure that no pressure was placed upon his spine. On both occasions, however, he was transported in a sitting position, causing him to experience severe pain and trauma.

She recalled that on his return from Cannock Chase Hospital to Ward 2 at Stafford Hospital she stayed with him for up to 12 hours a day. She deemed this *"absolutely necessary"*, as he had become totally dependent; however, there was an insufficient number of nursing staff available to provide him with the level of care he required.

Her husband developed large pressure sores on both of his heels. She recalled that *"time and time again his dressing had come off and his wounds were exposed to the air...This was at the time when MRSA was rife in the hospital."* She had to dress the wounds herself but the hospital did not even have the necessary creams and dressings for her to use. She recalled that *"his wounds smelled dreadfully and needed to be cared for properly."*

As his illness progressed, her husband began to feel increasingly confused and agitated, and was subsequently prescribed anti-psychotic medication. However, on a number of occasions, when he was particularly distressed, she checked his medication chart and found that he had not been given his medication.

She went on to document that when her husband *"desperately needed pain relief towards the end of his life, I had to keep asking for his syringe-drivers to be refilled when they emptied. It just didn't seem to be a priority. On two occasions, I waited for over an hour for a reply to the call-button and eventually I just had to go and find a nurse and insist that they left the patient they were with to come and help... He was crying by that time and in great distress due to the pain he was experiencing."*

Her husband reached the stage where she agreed with the doctor and the palliative care nurse specialist that her husband should just be kept comfortable and be given palliative care, and that no intervention or resuscitation was to be provided. As there was not a bed available at Katharine House Hospice, her husband had to remain at Stafford Hospital. His wife arrived on the ward on three separate occasions to find that he was being provided with oxygen therapy, antibiotics and a saline drip, which contravened the agreement made with the doctor and specialist and, in her opinion, served to *"prolong his distress and delay the inevitable".*

In the final stages of his illness her husband was not given any oral care, and she recalled that his mouth was in a *"dreadful mess"*. She had to ask for oral packs and attend to him herself. At this time, she noted that it was *"extremely distressing and difficult to do this for him".*

She concluded her correspondence by stating that her husband *"was a good man, a gentle man, who struggled with his disability and his lack of mobility for more than 16 years without complaint. He did not deserve to end his life in such an undignified manner and in such distressing circumstances."*

Conclusions and recommendations

Introduction

1. This has been a story of a trust which has, over a sustained period of time, failed to deliver acceptable standards of care to many of its patients. It is appropriate to echo a statement made by Florence Nightingale 150 years ago:

   It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.[100]

2. Unfortunately, this requirement has not been met at Stafford Hospital. While it is true that in some of its activities it has achieved good standards which have attracted praise, the deficiencies identified in this report are too widespread and too fundamental to be brushed off as isolated examples of lapses in standards that might be encountered in any healthcare organisation, however well run. What this investigation has uncovered is failure on a scale that cannot be adequately expressed in statistics – indeed, over-reliance on figures has been one of the reasons for the Trust's failings. If anything, the extent of the deficiencies uncovered is greater than that revealed by the Healthcare Commission's report, although the evidence I have heard does not give cause to question the broad thrust of its conclusions. The shock that is the appropriate reaction to many of the experiences the Inquiry has been told about, 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. While concerns may have been brought to light by mortality statistics, it would be misleading to deflect attention from the suffering caused to a wide range of patients whether or not their survival was prejudiced.

What went wrong?

A long-term failure

3. The deficiencies in staff and governance began before the period covered by the terms of reference of this Inquiry. Among the indicators of this are the following:

   - The quality of nursing during that period suggested that staffing levels had been acknowledged to have been too low as long ago as 1998.
   - The 2002 Commission for Health Improvement report highlighted a number of the deficiencies that we identified as occurring during the period under review.
   - There is evidence that financial issues were a concern at the Trust in 2004, if not before, when a vacancy scrutiny panel was set up; a plan for financial recovery had to be prepared in early 2005.

[100] Florence Nightingale (1859), *Notes on Hospitals*

- I have received accounts from patients and their families of poor care before 2005 which are very similar in character to reports of events occurring after that date.
- At the time Ms Toni Brisby was appointed Chair of the Trust she was informed it was a failing Trust.
- Many staff welcomed the arrival of Mr Martin Yeates as someone who would address the problems that had developed previously; even after the HCC report they perceived Ms Brisby and Mr Yeates as having improved the Trust's position since their arrival.

4. Any trust in which there have been serious organisational issues for a sustained period will be more difficult to turn around than one where there are isolated difficulties of recent origin. Long-term habituation, denial, lack of engagement and commitment, and weak leadership, among other difficulties, are hard to change.

Problems identified but not addressed effectively

5. A striking feature of the evidence given by senior management and others is that many of the issues which were the cause of complaints made by patients and their families, as well as the concerns expressed by staff, had been recognised and been made the subject of action. Unfortunately, this was ineffective action.

6. The lists of problems identified by Ms Brisby on her arrival as Chair in 2005 and by Mr Yeates, also in 2005, bear comparison with Mr Anthony Sumara's analysis of what was wrong on his arrival in 2009. Each of these lists contains the essence of what I have found to be wrong in a number of the areas looked at in this report.

Confused view of responsibilities

7. A constant theme from evidence about the Trust Board has been a retreat to the justification that its members were responsible for strategic and not operational direction. While this is obviously true, it is no excuse for not delving into the operational during times when it was known that there were no governance structures in place or only developing ones. It should have been realised that until reorganisation was embedded and proved to be effective, it could not be relied on exclusively. It was necessary for directors to roll up their sleeves and see for themselves what was actually happening.

8. A lack of clarity may have existed for a time over responsibility for nursing issues. Either there were differing perceptions held by the Director of Clinical Standards and the Chief Operating Officer about their roles or there was insufficient specification of the roles, or both.

A lack of urgency

9. Problems such as a lack of effective governance require urgent and comprehensive attention. They carry the necessary inference that safety and good practice are not assured, thereby prejudicing the interests of patients. Action to address problems of this importance require constant follow-up, review and modification where necessary. It is unacceptable that a staff review, which was quite correctly commenced because of perceived staff and skills shortages, should take as long to complete as did the one initiated by Dr Helen Moss. It is also questionable whether the action to recruit to an acceptable level should have been staged and therefore prolonged.

Figures preferred to people

10. A common response to concerns has been to refer to data, often of a very generic type such as star ratings, CNST levels and so on, rather than to the experiences of patients and their families. This is not to downgrade the importance of a collective and analytical approach to organisational assessment to draw attention to the only thing that really matters in a hospital – namely, individual patients. The story of Stafford, however, shows graphically and sadly that benchmarks, comparative ratings and foundation trust status do not in themselves bring to light serious and systemic failings.

A lack of risk and impact assessment

11. Significant changes have been seen to have been approved and implemented in the Trust without appropriate consideration of the risks involved. While risk assessment has sometimes been referred to, little evidence of it actually occurring and being reported has been found. While there may have been some work at middle management levels, it is not an area that appears to have concerned the Board as much as it should have done. The Board seems often to have worked on the assumption that such matters were operational not strategic.

A focus on systems not outcomes

12. While structures are an important and necessary part of governance, what is really important is that they deliver the desired outcome, namely safe and good quality care. There is evidence that setting up systems predominated over improving actual outcomes for patients: for example, the introduction of a new governance structure did not appreciably improve care for patients.

Those who received care were not listened to

13. Another aspect of the preference for figures rather than people has been the failure to listen, or to listen properly. Many of the complaints made to the Inquiry had already been made in precisely the same terms to the Trust. Many of them, even if taken on their own as one person's observation, should have been enough to alert a listener to the existence of a serious systemic problem. Often the responses were formulaic. Even where they were not, the action taken as a result was inadequate. Perhaps most importantly, representative stories hardly ever reached directors. Otherwise it is difficult to believe they would have been as shocked as they were when eventually Cure the NHS members were given a chance to speak to the Board.

Staff disengaged from the process of management

14. There are two elements to this. Staff expressed concerns, sometimes forthrightly and cogently, and were not listened to. For example, concerns were expressed about the clinical floors project and the workforce reduction proposal. These do not seem to have been addressed. Incident reports citing understaffing received no feedback. Secondly, a culture in which staff separated themselves from management sometimes prevented a coherent staff view from being presented. There was evidence of consultants not just being reluctant to join in management – a common enough cause for concern in hospitals in general – but also of being having little interest in the potential of such proposals to affect their own standards of service.

Insufficient attention to professional standards

15. There is evidence of a worrying acceptance of poor care, of poor behaviour among colleagues being condoned and of potentially dishonest behaviour being encouraged. Systems designed to improve performance, such as audit, appraisal and professional development, have been accorded a low priority by staff and management. Disciplinary processes seem to have been avoided even in manifestly serious cases.

Lack of support for staff

16. Staff in the difficult environment of a hospital deserve and are entitled to support, respect and recognition for good standards. They should not to have to contend with a culture of fear and bullying. Dedication, compassion and effective teamwork contribute to the welfare of patients and should be valued. Pride in achievement needs to be fostered. Above all, staff, both nursing and medical, are entitled to effective leadership at every level. A small unit such as a ward, which is well led and staffed by people familiar with each other's working practices, will functions more effectively than a ward whose staff have no collective sense of identity.

A weak professional voice in management decisions

17. The Board was entirely dependent for advice from qualified clinicians on the Medical Director and the Director of Clinical Standards/Nursing. Board members did not actively seek the views of the wider professional body on projects requiring this form of advice and input.

A failure to meet the challenge of caring for the elderly and the vulnerable

18. I am very grateful to Professor Black for his advice.

19. It will have become apparent that many of the cases in which patients and their families have reported concerns have involved elderly patients. The multiple needs of such patients in terms of diagnosis, management, communication and nursing care are in many ways distinct from those of younger patients. The latter can more often be safely treated only for the condition for which they have been admitted. Older patients will often present with a complex of medical and care problems requiring a skilled and all-embracing multi disciplinary team approach. Active management with the assistance of specialist advice will often be needed. The Trust had a service for the care of the elderly but there has been little evidence of its contribution in many of the cases of concern reported to the Inquiry.

20. Although there is evidence that patients were seen intermittently by various members of the multidisciplinary team, there is little evidence that there was a planned multidisciplinary approach to their care.

21. The evidence provided by witnesses also did not point to the ready availability of specialist medical advice for the elderly. There are four whole-time equivalent (WTE) geriatricians at Stafford and Cannock hospitals, serving a population of 320,000. Their time is split, approximately, between 40% at Stafford (354 beds) and 60% at Cannock (77 beds), implying 1.6 WTE geriatricians at Stafford. The Royal College of Physicians' guidelines recommend one geriatrician WTE per 50,000 population, which indicates that there should be 6.4 WTE across both sites.[101] Given that the majority of beds are at Stafford, any increase should probably be focused there.

22. It appears from the evidence presented at oral hearings that many patients suffered from acute confusional states; this occurs in a high proportion of older people admitted to hospital with serious illness. The evidence suggests that some medical staff did not understand this diagnosis and its importance and in some instances treated it as 'bad behaviour' rather than as a valid medical condition.

23. It has been submitted that some of what occurred at Stafford amounts to abuse of vulnerable adults. The broad definition of this term in the Protection of Vulnerable Adults scheme under the Care Standards Act 2000,[102] includes:

    ... neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

24. It would be wrong to suggest that such abuse has occurred in every case, but in some of the cases that have been recounted in oral evidence it would be right to say that it has. Whether or not patients were abused in terms of the Protection of Vulnerable Adults definition, many were subjected to treatment that cannot be justified. The Trust needs to look carefully at the way it provides care for the elderly, infirm and vulnerable on its acute admission wards.

A lack of external and internal transparency

25. The Inquiry has seen evidence of a significant lack of transparency. Internally, feedback in relation to complaints and incident reports was often absent. Clinical audit was not fostered, likewise mortality and morbidity reviews. Externally, the public was unnecessarily excluded from Board meetings, the degree of engagement with local bodies has been questioned, and in one serious case a report that should have been made available to the coroner was not sent.

[101] Royal College of Physicians (July 2008) 'Geriatric medicine', in *Consultant Physicians Working with Patients*, 4th edition, p. 177

[102] Paragraph 2.7; Department of Health (2004) *Protection of Vulnerable Adults Scheme in England and Wales for care homes and domiciliary care agencies – a Practical Guide*, paragraph 50

False reassurance taken from external assessments

26. The Board gained unjustified reassurance about the Trust's standard of performance from external assessments without taking into account the fact that most of these were based on information generated by the Trust itself. In any event, such reference points should not have discouraged them from fulfilling their duty to be aware of what was happening under their direction.

A disregard for the significance of mortality statistics

27. Too much comfort was taken from the coding as an explanation for concerning figures and insufficient consideration was given to other explanations.

What needs to be done?

28. the priority of a hospital trust must be the delivery of a high-quality service to patients. As the current Medical Director said:

    Our job is to treat patients. That is all there is to it.

29. This is already well recognised nationally in, for example, the Darzi report,[103] and locally by the Board's adoption of the Anthony Sumara's five principles.[104] This has a number of consequences which need spelling out:

    - All changes in service delivery, systems, equipment, staffing and resources must be measured against the impact on the standard of service provided. Therefore, no change should be authorised or implemented without:
      - timely, and recorded, consultation with professional staff who are to deliver or whose service will be affected by the proposed change;
      - a proportionate, thorough and objective impact assessment, recorded in writing.
    - Where a change is authorised or implemented contrary to the expressed views of any professional staff or where any impact assessment highlights a risk of reduction in the standard of service, the managers or directors taking the decision must record their reasons for doing so in writing.
    - It should be recognised that where a standard of care acceptable to patients and the public, or sufficient professional staff to provide that care, cannot be delivered for financial or other reasons, the relevant service should be closed or suspended until such standard can be achieved.

[103] DH 2008: High quality care for all: NHS Next Stage Review Final report

[104] The five principles are as follows: Creating a culture of caring; Seeing zero harm as our target by keeping patients safe; Listening, responding and acting to what our patients and community are telling us; Supporting our staff to become excellent. Giving responsibility but holding to account as well; Business and regulatory matters

- Patients, former and present, those close to them and members of the community served by the Trust must be constantly engaged and consulted in relation to issues about service delivery to establish their needs and views. Such engagement should be fostered at every level of the organisation from the ward to the Board.

Recommendation 1: **The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard.**

Should the hospital be closed?

30. The idea that the hospital should be closed has been expressed by some. I firmly reject it. It is clear to me, from considering the views of hundreds of members of the public who have contacted the Inquiry, that, overwhelmingly, people want to retain the hospital and see it improve. I received a significant number of letters from patients praising the care they had received and the staff who had provided it. Many patients who gave oral evidence spoke of restoring pride in their local hospital. Its importance as part of the fabric of the local community should not be underestimated. Even many of those who complained of bad care were at pains to point to other episodes of treatment which had been of a high standard. What they all require is assurance that there is an effective management team taking the necessary steps, as a matter of urgency, to change those areas of service which are unsafe or poor. Closure of the hospital would leave the community worse off than it is at present.

Foundation trust status

31. There is an argument that foundation trust status should not have been granted to the Trust, whatever compliance was theoretically shown with the criteria applied at the time. For example, the then Board's declaration that the Trust delivered a high standard of care was clearly fundamentally misleading. One option is for the Trust to be de-authorised under the provisions of the Health Act 2009[105] and returned to the supervision of the strategic health authority (SHA). Such a radical step could have advantages.

[105] Health Act 2009, section 15, inserting section 52E of the NHS Act 2006, which enables the Secretary of State to make a written request to Monitor to exercise its power to give a de-authorisation notice

- It would allow a renewed foundation trust application to be made, if thought appropriate, in the knowledge of the true history and against revised criteria as informed by the experience of the earlier application: were foundation trust status to be granted again, it would give the public confidence that the Trust was now truly fit to become a foundation trust, and could be properly described, as it was by the former Chair, as being in *"the premier league"* .
- Until such time, the responsibility for ensuring that the Trust achieves the required standards and makes any necessary managerial or structural changes would be returned to the SHA and, through it, the Department of Health with all the oversight powers available to them.

32. There are, however, potential disadvantages:

- A radical and complex change of this nature runs the risk of diverting managerial resources away from the immediately required internal changes. There is evidence that the current managerial team has grasped the need for such changes.
- There are bound to be financial implications in what is already a challenging fiscal environment.
- The flexibility accorded by independence as an foundation trust would be lost, perhaps thereby slowing down the pace of change and improvement.
- While the support they receive needs to be improved, the loss of foundation trust status would result in the loss of the contribution of the foundation's governors and Board members.

33. Therefore, my provisional conclusion is that removal of foundation trust status may well not be the appropriate way forward. However, I consider the option should be kept firmly in mind and held in reserve should the hoped-for improvements not continue. I also consider that this is a matter that the Secretary of State should consider in the light of this report and all other information now available about the Trust.

Recommendation 2: **The Secretary of State for Health should consider whether he ought to request that Monitor – under the provisions of the Health Act 2009 – exercise its power of de-authorisation over the Mid Staffordshire NHS Foundation Trust. In the event of his deciding that continuation of foundation trust status is appropriate, the Secretary of State should keep that decision under review.**

External service engagement

34. Stafford and Cannock are relatively small hospitals undertaking a wide range of activity. As treatments become more sophisticated and care more specialised, there is a good case, as pointed out by Professor Alberti, for hospitals to focus on what they can do well, and for arrangements to be made for other services to be provided either elsewhere or in cooperation with other facilities that have the necessary skills. It is striking that although Stafford is in relatively close proximity to a number of other hospitals, for example in Stoke, Wolverhampton and Burton, there appears to have been limited interaction in those areas of concern that have figured prominently in the Inquiry. Cooperation has taken place in at least some areas where good practice has been found. For example, in rheumatology, run from Cannock, activities and staff are jointly funded by different primary care trusts (PCTs) and the consultant has clinics at several sites.

35. There is a strong case for a review of each service with a view to working out how it might be strengthened by links with neighbouring trusts. I am grateful for the advice I have received from Professor Black about how links can be fostered in a number of ways.

    - Merger: as with the removal of foundation trust status, while there may be benefits in terms of the introduction of better working practices and management from elsewhere, there is a risk that such changes would divert resources and attention away from the services actually requiring improvement. As Professor Black points out, it can take many years to achieve and bed down a merger. It might also prove challenging to persuade successful organisations to take on Stafford and its issues.
    - Secondments: opportunities could be provided for clinicians from elsewhere to assist in the improvement of standards and function within the Trust and to assist in leadership where this is lacking.
    - Joint appointments: as with the model provided by rheumatology, joint appointments could be made to consultant positions. This would reinforce what Professor Black has described to me as the *"network of care"* which can, if necessary, be based on a large teaching hospital. There are already networks in the form of clinicians' meetings in oncology but these could be reinforced by one or more joint appointments. The availability of opportunities for clinical working within different trusts or hospitals might assist in the recruitment of high-calibre clinicians and overcome the deterrent effect of the Trust's current difficulties.

Recommendation 3: **The Trust, together with the Primary Care Trust, should promote the development of links with other NHS trusts and foundation trusts to enhance its ability to deliver up-to-date and high-class standards of service provision and professional leadership.**

Training and professional development

36. I am grateful for the advice I have received from Professor Black, Professor Hutton and Ms Hart on this area.

37. Appraisals:

- The appraisals process must be enhanced and insisted upon. This should apply to all staff from top to bottom of the organisation and encourage people to express and receive constructive criticism of their peers. There should be leadership by example and systematic management of the process.
- Through the appraisals process, a professional development plan should be developed and maintained for each member of staff.

38. External links:

- Links could be fostered with teaching hospitals in order to improve the opportunities for training and professional development for staff at all levels.
- Staff should be encouraged to attend externally arranged educational and training events.
- External training bodies, including the Royal Colleges, the local Deanery and the Royal College of Nursing, should be invited to review training and development arrangements and suggest improvements.

39. Supervision/mentoring:

- All junior medical staff and nursing staff of all grades should be provided with support in the form of supervision sessions with immediate managers. In addition, a peer-based mentoring system would allow staff to address issues of concern in a confidential and threat-free environment.
- A number of my advisers, as well as consultants and medical directors who attended the Inquiry, have discussed the impact of the European Working Time Directive (EWTD) on the training and availability of junior doctors. I suggest that the Trust should review the impact of the EWTD on the training and out-of-hours performance of junior staff and report any resulting concerns to Monitor.

Recommendation 4: **The Trust, in conjunction with the Royal Colleges, the Deanery and the nursing school at Staffordshire University, should review its training programmes for all staff to ensure that high-quality professional training and development is provided at all levels to and that high-quality service is recognised and valued.**

Audit

40. A serious deficiency in the performance and resourcing of clinical audit has been disclosed in at least some areas of activity. The impression given is that practice and attitudes in relation to this are considerably out of date.

    - Clinical audit should be adopted in accordance with national standards in each area of activity.
    - Resources should be made available to enable proper audit processes to be followed.
    - Clinicians should be allocated specified time in the working month in which they are required to engage in audit and related activities.
    - Compliance with the requirement to engage in audit should be monitored by the Board on a regular basis and the extent of participation reported to the public in the Trust's quality account, a statutory obligation from 2010. The Board should also consider publishing the outcomes of the audit process.

Recommendation 5: **The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.**

Complaints and incident reporting

41. Serious deficiencies have been identified in the complaints and incident-reporting process. These have included a lack of feedback to the staff involved, repetition of action plans which have not been executed and a failure to report matters with sufficient clarity to the Board to enable problems to be identified and addressed. It is therefore essential that action is urgently taken to improve these processes. I suggest that the following steps are worthy of consideration.

- The Trust should consider integrating the complaints and incident-reporting systems.
- The Board should ensure that a non-executive director has responsibility for oversight of the complaints and incident-reporting system.
- The facts of a representative sample of complaints and incidents should be reported to the Board regularly. Directors should be available to meet complainants. They should be encouraged to investigate personally a sample of complaints.
- The view of front-line staff in the service affected should be obtained and recorded in the report about the complaint.
- The outcome of the investigation of any complaint and the incident report, as well as any action plans, must be communicated not only to the complainant but also to the front-line staff in the services affected.
- The execution of action plans must be reviewed on a regular basis and the progress made reported to the complainant and the Board.
- Complaints and incidents should be reviewed on a regular basis by the governors and reported to the local authority scrutiny committees.

Recommendation 6: **The Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this report and ensure that it:**

- **provides responses and resolutions to complaints which satisfy complainants;**
- **ensures that staff are engaged in the process from the investigation of a complaint or an incident to the implementation of any lessons to be learned all part of the recommendation**
- **minimises the risk of deficiencies exposed by the problems recurring; and**
- **makes available full information on the matters reported, and the action to resolve deficiencies, to the Board, the governors and the public.**

Professional oversight and discipline

- Where unacceptable practice is identified or alleged on reasonable grounds, it is important that swift action is taken to protect patient safety and public confidence in the service provided by the hospital, whether by way of remedial training or other action, referral to the NCAAS, or referral to the General Medical Council.
- Such action must include suspension of the practitioner, where such a step is necessary to protect patient safety and the public interest, while the matter is fully investigated.

- Not every serious untoward incident involving an error or misjudgement on the part of a practitioner will require such a step, but in every such case management must consider what action is necessary and proportionate to protect the interests of patients and the public.
- Where external reviews identify deficiencies or matters of concern with regard to the medical or nursing staff, immediate consideration must be given to what steps are required to remedy the deficiencies, and whether the review has sufficiently addressed the issues under investigation.

Recommendation 7: **Trust policies, procedures and practice regarding professional oversight and discipline should be reviewed in the light of the principles described in this report.**

Staff concerns/whistle-blowing

42. It is clear that there is a very real reluctance on the part of staff at all levels of seniority – to persist in raising concerns about unsafe or substandard services, colleagues' capability and conduct, and similarly important issues. There is a widespread belief that the protections offered are theoretical rather than real. The most important factor in changing this will not be a new system or policy of protection for whistle-blowers, but the fostering of a culture of openness, self-criticism and teamwork. The Trust must foster an atmosphere in which constructive criticism is welcome, debate on issues of concern are encouraged and acceptance of change is regarded as positive. This requires leadership by example at all levels as well as a reinforcement of the formal protections available.

    - The Chair and all executive directors should be appraised like any other member of the organisation and staff should be encouraged to offer views on their performance. Where a criticism is made, it should be addressed openly and an example of accepting and acting upon it should be given.
    - The Trust must be candid in accepting publicly that errors and lapses from appropriate standards have occurred, when these are identified. Thus, where errors and lapses are identified which have or may have caused harm to a patient, the Trust should volunteer the information to the patient, or if deceased to the patient's personal representatives, whether or not a complaint or claim has been made.
    - Where external agencies make a criticism of the Trust or raise concerns about its service delivery, it should responsibly consider whether this is justified and, where it is, say so in the appropriate forums.

- Clinicians and nursing staff and other qualified front-line staff should be encouraged to participate together in regular reviews of practice in their areas of activity. Such reviews should include mortality and morbidity meetings, reviews of complaints and incidents, and ward staff meetings. Attendance at such meetings should be required and should be part of the paid working day. Suggestions for changes in practice should be welcomed from all sources.
- Staff at all levels should be reminded of their obligation to assist the Trust to improve its standards by advising management or responsible colleagues of their concerns.

43. No employee should suffer any adverse consequences from management or colleagues for raising or reporting, whether internally or externally, concerns relating to the standard and safety of care provided to patients based on a reasonably held belief, even if an investigation subsequently concludes that there are no grounds for such a concern. It should be a disciplinary offence for any member of management or a colleague to act in a way which is prejudicial to the continued employment of that employee or detrimental to his/her well-being because of the raising or reporting of such concerns. Where any member of management or staff acts in such a way knowing that the affected employee has raised such concerns, it should be presumed for the purpose of the disciplinary procedure that such action was because of the raising or reporting of those concerns, unless the contrary is proved.

Recommendation 8: **The Board should give priority to ensuring that any member of staff who raises an honestly held concern about the standard or safety of the provision of services to patients is supported and protected from any adverse consequences, and should foster a culture of openness and insight.**

Accountability

44. Concern has been understandably expressed about the process whereby Mr Yeates left his post as Chief Executive. Many of those affected by the poor care provided at Stafford have expressed the view that he should have been held to account, in particular by this Inquiry. As I have explained, this Inquiry was not set up to bring individuals to account, other than in the sense of questioning them about what has happened. In the case of Mr Yeates, this has not been possible because of health reasons. I have, however, investigated the process that surrounded his departure from the Trust and have found that it was inappropriate and took insufficient account of the public interest. In fairness, however, the Board was acting on advice received and in the absence of any system of formally bringing executive officers to account. This is to be contrasted with the

formidable monitoring and disciplinary systems in place for registered healthcare professionals.

45. Lord Darzi's final report of the Next Stage Review announced plans to strengthen the recruitment, governance and accreditation of managers. Of these, accreditation is the most complex and least developed so far. Across professions, there is a move away from a system built on self-regulation. This case highlights the need for a proper system of ensuring the accountability of executive officers and non-executive directors of trusts and foundation trusts. There are a number of elements to this.

    - First and foremost, persons recruited to these highly important and challenging posts must be equipped to do them. This requires defined, generally accepted and published national competency criteria for each post.
    - There must be external independent verification of the competence of candidates and those aspiring to such posts by accreditation or similar means.
    - There must be training schemes to enable and empower suitable candidates to undertake these roles effectively.
    - For executive posts, the career structure should encourage the best of NHS staff to seek them, while not discouraging those with appropriate skills developed outside the NHS.
    - A professional ethos must be promoted by establishing the standards, preferably in conjunction with an association of executive leaders, by which it is accepted that they be judged.
    - An independent forum should be created which is empowered to determine allegations and complaints about the fitness of individuals to be appointed as executive and non-executive directors of NHS bodies, including foundation trusts.
    - The terms of any agreed termination of employment should provide that they can be reviewed if, within a specified period after the end of the contract, it is determined that serious deficiencies in conduct or performance have been established.

Recommendation 9: **In the light of the findings of this report, the Secretary of State and Monitor should review the arrangements for the training, appointment, support and accountability of executive and non-executive directors of NHS trusts and NHS foundation trusts, with a view to creating and enforcing uniform professional standards for such posts by means of standards formulated and overseen by an independent body given powers of disciplinary sanction.**

Management of nursing staff

46. I am concerned that the staff in the hospital in general, and the nursing staff in particular, are thoroughly demoralised as a result of the events of the last few years. I believe that many have adopted a survival strategy of going through the motions of doing their job as opposed to pursuing a much valued and necessary vocation. I consider that urgent steps are needed to re-energise and focus the staff on doing what I am convinced they can do well: they need to believe they are valued, that their professional views are respected and listened to, and that proper recognition is given to good practice. I am not convinced, any more than many nurses appear to be, that the introduction of no fewer than 12 matrons offers the solution – and certainly not the whole of it. I believe that steps need to be taken to ensure that:

- all front-line nurses are identified as part of a team which has defined responsibilities, and to the success of which they are expected to contribute;
- each team has one or more leaders who are expected to lead by example, to support all members of the team to perform to a high standard, and to listen to and pass on professional concerns expressed by team members;
- an ethos is fostered which makes the welfare of patients the first priority, promotes constant improvements in the standard of service provided to patients, and provides for ready and open acknowledgment of instances where an appropriate standard has not been maintained;
- nursing management is structured in such a way that the views and experience of front-line staff are transmitted through the system to the Board;
- nurses are supported by training, mentoring and professional development to enhance their skills and knowledge; and
- the Director of Nursing has responsibility for properly representing the views of the nursing staff to the Board.

Recommendation 10: **The Board should review the management and leadership of the nursing staff to ensure that the principles described are complied with.**

Medical staff

47. All consultants need to recognise that they have a responsibility to engage with and participate in the management of the service in which they work, to promote the interests and welfare of their patients. Individually and collectively they must recognise their obligation to raise concerns about poor practice or provision of service that prejudices their patients' welfare or safety. They should offer to participate in the leadership of staff who share in the provision of patient care.

Recommendation 11: **The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on matters relating to the standard and safety of the service provided to patients.**

Record keeping

48. The standard of record keeping has been found to be poor and inconsistent. Patient care and safety are prejudiced by such lapses, and failure to complete records properly exposes the Trust to the risk of being found liable for mistakes that may be assumed to have occurred if no record is made of the required action. For these and many other reasons it is essential that proper standards are insisted upon.

Recommendation 12: **The Trust should review its record-keeping procedures in consultation with the clinical and nursing staff and regularly audit the standards of performance.**

Care of the elderly

49. This Inquiry is as much a story of very poor nursing care as of anything else; nursing care that lacked attentiveness and compassion and let down too many frail, older, vulnerable people. The challenges of an ageing population are well known but, in the case of Stafford, the need to deliver hospital care according to the needs of older people was overlooked.

Recommendation 13: **All wards admitting elderly, acutely ill patients in significant numbers should have multidisciplinary meetings, with consultant medical input, on a weekly basis. The level of specialist elderly care medical input should also be reviewed, and all nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion.**

The promotion of a good standard of care

50. It may surprise some that the vast bulk of the complaints reviewed by the Inquiry have not concerned medical neglect or errors leading to injury or death – although this report contains examples of these – but serious departures from the standard of basic care which every patient is entitled to expect. The importance of treating people with care, sympathy, patience and respect cannot be overstated; failure to do this blights not only the experience of the patients directly affected but also of those close to them, and often others who happen to witness the resulting suffering. Never again should patients and those close to them be subjected to the experiences described in this report. Staffing must be adequate to ensure a proper level of basic care; training, support, supervision and leadership must be strong enough to mean that there is no excuse for members of staff to behave as some have in this hospital. A clear statement of principles to be followed needs to be adopted and followed through.

Recommendation 14: **The Trust should ensure that its nurses work to a published set of principles, focusing on safe patient care.**

Mortality statistics

51. As discussed in some detail in Section G, having looked at the evidence, I am concerned by the ongoing uncertainty surrounding the use of comparative mortality statistics. This is likely to undermine public confidence.

Recommendation 15: **In view of the uncertainties surrounding the use of comparative mortality statistics in assessing hospital performance and the understanding of the term 'excess' deaths, an independent working group should be set up by the Department of Health to examine and report on the methodologies in use. It should make recommendations as to how such mortality statistics should be collected, analysed and published, both to promote public confidence and understanding of the process, and to assist hospitals in using such statistics as a prompt to examine particular areas of patient care.**

External organisations

52. Having considered the evidence and representations referred to in Section H, I conclude that there is a need for an independent examination of the operation of each commissioning, supervising and regulatory body, with respect to their monitoring function and capacity to identify hospitals failing to provide safe care: in particular:

    - what the commissioners, supervisory and regulatory bodies did or did not do at Stafford;
    - the methods of monitoring used, including the efficacy of the benchmarks used, the auditing of the information relied on, and whether there is a requirement for a greater emphasis on actual inspection rather than self–reporting;
    - whether recent changes, including the 'Memorandum of Understanding' between Monitor and the Care Quality Commission (CQC), Quality Accounts and the registration of trusts by the CQC, will improve the process by which failing hospitals are identified;
    - what improvements are required to local scrutiny and public engagement arrangements; and
    - the resourcing and support of foundation trust governors.

53. This Inquiry has received many demands that there should be a public inquiry. One of the elements of such an inquiry, it has been suggested, should be the investigation of the external bodies mentioned above. I do not consider it is appropriate for me to suggest that a public inquiry (in the sense of an Inquiries Act inquiry) is the only way in which these issues can be addressed, but it is certainly a way in which it could be done.

Recommendation 16: **The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified.**

Rebuilding the confidence of the public

54. Because of the unfortunate events giving rise to this Inquiry, there is a desperate need for measures that will rebuild the public's confidence in the Trust and the services it provides. I suggest that the following steps would help and are worthy of consideration.

- **Strengthening the role of the governors –** In addition to better resourcing and support, the governors should be invited to appoint a vice chair who would normally conduct meetings and set the agenda, in place of the current procedure whereby the Trust Chair performs this role. This would give governors more control over their business and ability to challenge the direction of the Trust.
- **Promoting an open culture –** The Trust could promote an open culture by a focus on activities such as public meetings to discuss its work, recruitment of volunteer assistants, regular publication of information about complaints, incidents and remedial action, as well as its achievements. Some of this is already happening.
- The PCT should keep the case note review open to enable those who have approached the Inquiry to consider whether they wish to request a review.
- The Trust should foster closer engagement with scrutiny committees.
- The Trust should promote links with community groups to provide additional means of exchanging information about itself and about any concerns raised.
- The Trust should make full use of the new statutory requirement for trusts to publish quality accounts to ensure that progress towards high-quality care is led by the Board and that the public is provided with meaningful information on outcomes of care.

Recommendation 17: **The Trust and the Primary Care Trust should consider steps to enhance the rebuilding of public confidence in the Trust.**

55. There are those who have given evidence or written to the Inquiry suggesting that Stafford is not an isolated case, and that, on the contrary, similar stories could be uncovered in other parts of the NHS. Clearly, it has not been a function of this Inquiry to undertake a survey of the NHS as a whole and therefore I cannot draw conclusions about this understandable concern. However, patients' stories very similar to those I have heard have been reported from elsewhere and with some frequency; examples can be found in the recent Patients Association report.[106] Nevertheless, what has been striking about the evidence drawn together by this Inquiry is the bad experiences were spread right across the hospital and occurred over many years. If this were a typical picture of an NHS district hospital, then this country's system of public healthcare would be in a truly shocking state. Clearly, every Trust should examine this report, including the case studies in volume 2, and undertake a candid self-assessment to work out whether such lapses are occurring or could occur in its own service. It is vital to remember that much of what the Healthcare Commission, Dr Colin-Thomé, Professor Alberti and I found to be wrong in Stafford was not known about by the Trust's Board or external bodies until it was too late. Therefore, false comfort should not be drawn from any absence of information indicating concerns.

Recommendation 18: **All NHS trusts and foundation trusts responsible for the provision of hospital services should review their standards, governance and performance in the light of this report.**

[106] Patients Association (August 2009) *Patients... not numbers, People... not statistics*

Glossary, Appendices and Bibliography

Glossary

In this report the following terms are intended to convey the meaning indicated unless the context makes it clear a different meaning is intended.

Term	Definition
A&E	Accident and Emergency Department
the Board	The Trust Board
C. diff	*Clostridium difficile*
Clostridium difficile	A serious bacterial infection capable of causing severe gastrointestinal symptoms, frequently acquired in hospital
CQC	Care Quality Commission (from April 2009)
CTNHS	Cure the NHS
EAU	Emergency Assessment Unit
HCC	Healthcare Commission (until March 2009)
HMB	Hospital Management Board of the Trust
the Hospital	Stafford Hospital
HSMR	Hospital Standardised Mortality Ratio
the Inquiry	This inquiry
JNCC	Joint Negotiating and Consultative Committee
the PCT	South Staffordshire Primary Care Trust
the SHA	West Midlands Strategic Health Authority, or its predecessors (usually Shropshire & Staffordshire SHA)
the SMR	Standardised Mortality Rate
SUI	Serious Untoward Incident
the Trust	Mid-Staffordshire Foundation NHS Trust, formerly the Mid-Staffordshire NHS Trust
WTEs	Whole time equivalent posts

Appendix 1

Written Ministerial statement 21 July 2009

Written Ministerial Statement

DEPARTMENT OF HEALTH

Mid-Staffordshire NHS Foundation Trust

Tuesday 21 July 2009

The Secretary of State for Health (Andy Burnham): On 17 March 2009, the Healthcare Commission, the independent health regulator, published a damning report into the failings of emergency care provided by Mid-Staffordshire NHS Foundation Trust. Since then, the Government and the local NHS have had two priorities: first to ensure services at the trust improve as soon as possible to the level that patients and the public have a right to expect; and second to ensure the right lessons are learned both locally and nationally, so the events of Mid-Staffordshire cannot be repeated.

The previous Secretary of State commissioned two rapid reviews from Professor Sir George Alberti (National Clinical Director for Emergency Care) on the present state of emergency services at the trust and Dr David Colin-Thome on how the broader system was not able to detect the failings sooner. All their recommendations were accepted and the reports were published, alongside the Government's response on 30 April 2009.

The new independent regulator for health and social care, the Care Quality Commission, has today published their three month stock-take report. In short, they conclude there has been some progress, but there is much more to do. Their analysis echoes the concerns that Ministers have heard from members of the local community.

Having listened carefully to these concerns, I have resolved that further action is necessary. Today I am announcing a package of measures to lead to a step change in improving local services and to help heal the wounds of the past, so the trust and their local community can face the future together with renewed confidence and optimism.

I have worked closely with Monitor, the Foundation Trust regulator, to ensure a new leadership team with the skills and experience to transform services at the hospital is appointed as a matter of urgency. I am pleased to welcome Sir Stephen Moss, the new Chair, and Antony Sumara, the new Chief Executive, to their roles. Monitor and the Care Quality Commission will continue to oversee their progress, with a further review due in October.

Fundamental to the trust's success will be listening to patients, to ensure their voice counts and that they are an integral part of shaping and influencing the future of the hospital. That is why I have asked Dr. David Colin-Thome to support and advise South Staffordshire Primary Care Trust to play their full part alongside the trust in reaching out and involving people locally.

It is clear from listening to those affected that rebuilding local confidence and restoring trust will take time. The full impact of what happened at Mid-Staffordshire is revealed through the personal stories of those affected and it is clear to me that these experiences need to be properly aired if the local NHS is to learn and, in time, move on.

I have therefore decided, following detailed discussions between my department and the new management of the trust, that it would be appropriate to set up a further independent inquiry. I do not believe it is necessary for this to be a full public inquiry, given the thoroughness of the reports already produced by the Healthcare Commission, Professor Sir George Alberti and David Colin-Thome, as well as the availability of an Independent Clinical review to those who have concerns about the care they or a loved one received at the hospital.

This inquiry's focus will be on ensuring that patients or their families have an opportunity to raise their concerns. It is important, given the events of the past, for those who depend upon the care provided by the trust to be confident that they have been listened to and that any further lessons not already identified by the thorough inquiries that have already occurred be learned.

Robert Francis QC has agreed to Chair the Inquiry. The terms of reference (a full copy has been placed in the Library) will be:

> to investigate any individual case relating to the care provided by Mid Staffordshire NHS Foundation Trust between 2005 and 2008 that, in its opinion, causes concern and to the extent that it considers appropriate;
>
> in the light of such investigation, to consider whether any additional lessons are to be learned beyond those identified by the inquiries conducted by the Healthcare Commission, Professor Alberti and Dr Colin-Thome; and, if so,
>
> to consider what additional action is necessary for the new hospital management to ensure the Trust is delivering a sustainably good service to its local population; and
>
> to prepare and deliver to the Secretary of State a report of its findings.

It is important that this is swift so as not to unduly distract the new management and staff at the hospital from improving services for patients today. The inquiry is therefore planned to report to me by the end of 2009. Should the Chair of the inquiry consider that it is necessary to have the power to require witnesses to attend, as Secretary of State, I have the power to convert the inquiry into an inquiry under the Inquiries Act 2005.

There are also national lessons to learn from the investigation at Mid-Staffordshire. Dr David Colin-Thome's report contained some important recommendations on this.

Many of these are already being addressed for example through the implementation of Lord Darzi's vision High Quality Care for All and our World Class Commissioning programme. In addition, the new National Quality Board will report to me by the end of the year with recommendations on how best to ensure any early signs that something is going wrong in the NHS are picked up immediately, that the right organisations are alerted, and action is taken quickly.

The Mid-Staffordshire case has also illustrated that the current regulatory framework for foundation trusts (FTs) needs updating. The FT model is a key plank of reform in the NHS, successfully rewarding high performance with greater freedom and autonomy. The policy is based on the premise that FT status is a privilege to be earned and valued – an incentive to drive up quality, innovation, productivity and local accountability. However, it is clear that in some exceptional circumstances, where an FT has failed to live up to this standard and public confidence has been damaged, it may be right for the privileges of FT status to be withdrawn.

This is why I intend to consult on legislative proposals to enable Monitor to 'de-authorise' a foundation trust, subject to agreement by the Secretary of State, where it is clear an organisation has forfeited its right to the freedoms and flexibilities afforded by FT status. It is also important that where there is public concern, the Secretary of State is able to express his views and request that Monitor considers intervention in a particular way. I will also consult on legislative proposals so that, in these circumstances, if Monitor disagrees with the approach suggested by Ministers, they should be obliged to justify this position publicly. The Government will issue a consultation on both these issues in the next few days.

By focusing on the powers and actions of Monitor to intervene, I believe we achieve the appropriate balance between ensuring fundamental failure is addressed and maintaining the significant benefits of the FT model, which gives FTs greater freedom in return for high quality.

All of us who care passionately about the health service were appalled by the events at Mid-Staffordshire, which are in stark contrast to the dedication and professionalism shown by NHS staff every day up and down the country. The measures I have announced today, building on those already taken, demonstrate the collective commitment in all parts of the system, to ensure there will be no repeat.

Appendix 2

Letter from the Secretary of State for Health 10 September 2009

From the Rt Hon Andy Burnham MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000

POC1_443438

Robert Francis QC
3 Serjeants Inn
London
EC4Y 1BQ

10 SEP 2009

Dear Robert,

Thank you for updating me last week about the initial progress with the Mid-Staffordshire Inquiry. I am pleased you have already met with many of the key interested parties and gathered initial views about the work of the Inquiry.

We discussed two main points: the legal status of the inquiry and its terms of reference.

Legal Status
I announced the Inquiry to assist with both learning and healing in Mid- Staffordshire, for staff and patients. As such, and, given all the other reports that have been produced on Mid-Staffs, I remain of the view that it would be best served by an inquiry set up under the NHS Act rather than the Inquiries Act.

I do of course appreciate that the attendance of those witnesses you feel are pertinent to these aims is very important. Therefore, I do not rule out looking again at the status of the Inquiry once it has proceeded for a reasonable period, should you feel the co-operation of witnesses makes a compelling case to do so. However, I do hope that all concerned will understand that we will move on more easily in a spirit of co-operation and I would be grateful if you could emphasise this as your Inquiry proceeds.

Terms of Reference
We also spoke about the Inquiry's Terms Of Reference. You explained it has been suggested that the Inquiry's scope be expanded to also look beyond the Trust - at the wider system - in relation to the events at Mid-Staffordshire. I have been clear that the Inquiry's main purpose is to provide the opportunity for patients or their families to air their experiences and for any further lessons to be learned. In light of the reports already produced by the Healthcare Commission, Professor Sir George Alberti and David Colin-Thome - and the fact I am due to receive advice from the National Quality Board – I remain firmly of the view that an expansion of the scope is unnecessary and would detract from the need to focus on listening to families and patients

Moreover, any expansion in scope would risk preventing the Inquiry from being completed within the timescale I have set out. A swift Inquiry is important so as not to unduly distract staff at the hospital from delivering the improvements in services necessary for local

AG 10.09

DH Department of Health

people. However, following the hearings, you could – if evidence compelled you to - offer additional observations in your final report, as long as they are set in the context of the changes that have been made since the events took place.

We also touched on the time period under consideration. You said you felt there was a need to extend it up until the date the Healthcare Commission's report was published in March 2009 – both as it seems a logical end point but also because of further cases brought to your attention. When we chose the timescale we had the following in mind:

- the need for the Inquiry to be focused on lessons learned for the Trust today, and for a swift outcome so as not to distract hospital staff unnecessarily from delivering improvements;
- the fact that Dr David Colin-Thome's report considered information going further back than 2005 and that Professor Sir George Alberti's report considered the standard of care in the Trust post 2008; and
- that certain ICRs will fall outside the dates 2005 – 2008 but will still be able to contribute to any analysis of key themes and lessons to be learned arising from that process

I am concerned that any increase in the time period could have repercussions for the tight timescale we have set out for the Inquiry's completion. However, I am content to accept your suggestion of moving the end point to the date of publication in March 2009 to allow it to consider individual cases up to that point - on the understanding that this does not jeopardise the timescales for the final report and that it does not lead to any expansion in the issues covered by the scope.

I am very grateful for the work you are undertaking and look forward to receiving your report by the end of the year.

Best wishes,

Andy Burnham

ANDY BURNHAM

Appendix 3

Members of Inquiry secretariat including advisors

Chairman – Robert Francis QC, 3 Sergeants' Inn

Counsel to the Inquiry – Keith Morton, 1 Temple Gardens

Counsel to the Inquiry – Benjamin Hay, 1 Temple Gardens

Counsel to the Inquiry – Joanna Hughes, 1 Temple Gardens

The Inquiry Secretariat:

Secretary to the Inquiry – William Vineall

Deputy Secretary – Stephanie Somerville

Assistant Secretary – Mike Davies

Communications Lead – Rachel Carr

Secretariat Manager – Clare Callaghan

Administrative Support – Matthew Grossett, Nicholas Rees, Michael Bradley

Additional support (volume 1) was provided by Amber Sargent, Senior Consultant, Verita

Additional support (volume 2) was provided by Natasha Draycott & Hannah Pye, 5 St. Andrews Hill

The Inquiry was also assisted by Verita health consultants

The Inquiry also received advice from a number of independent advisors:

Tony Allen

Tony Allen was for over 30 years in private practice as a litigation solicitor, specialising in personal injury and clinical negligence. He joined CEDR (the Centre for Effective Dispute Resolution) as a Director in 2000, with special responsibility for developing the place of mediation in civil justice, and for mediation in the personal injury and clinical negligence sectors. He consulted with the Healthcare Commission in setting up a mediation pilot for complaints reviews. He was responsible for designing the mediation of the retained organs litigation, himself mediating the national group claim. He handles a wide range of healthcare, public law and injury mediations. He has been rated in successive editions of Chambers and Legal 500 as a leading mediator in his field. He is a lead member of CEDR's Training Faculty, and has run mediator skills accreditation courses for CEDR in the UK and in Europe, Africa, Pakistan, India and Hong Kong. He is a Trustee of the Clinical Disputes Forum and led the team which drafted its Guide to Mediating Clinical Claims. He also writes and speaks worldwide on ADR and the law, and is co-author of the second and third editions of the leading textbook *The ADR Practice Guide* by Mackie Marsh Miles and Allen.

Mary Baker

Mary Baker, MBE, is Patron and Immediate Past President of the European Parkinson's Disease Association (EPDA), a position she was elected to in 1992 when the EPDA was first formed. Mary retired as Chief Executive of the Parkinson's Disease Society of the United Kingdom in 2001 where she had worked for 18 years.

Mary is also President of the European Federation of Neurological Associations, Vice President of the European Brain Council, Consultant to the World Health Organisation (WHO) and Chair of the Working Group on Parkinson's Disease formed by the WHO in May 1997.

In 2008 the Council of Europe re-appointed Mary for a second term as one of the patient representatives to serve on the Management Board of the EMEA, and in the same year she was appointed to the IMI JU Scientific Committee. In 2007 Mary was appointed to the Council of the ABPI and she is also a Member of the ABPI Code of Practice. Other appointments include Director at Large for the World Stroke Association, former patient editor of the BMJ (now Chair of the BMJ Patient Advisory Group).

In 2009 Mary received the British Neuroscience Association Award for *Outstanding Contribution to British Neuroscience and for Public Service* and in 2003 an Honorary Doctorate from the University of Surrey was conferred upon her in recognition of work within the world of Parkinson's disease.

David Black

Professor David Black MA MBA FRCP FAcadMed, has been a Consultant Physician in Geriatric Medicine at Queen Mary's Hospital, Sidcup, since 1987 and was Medical Director from 1997 to 2003. He was Honorary Secretary of the British Geriatrics Society (BGS), then Chair of the Joint BGS/RCP Geriatrics Committee and elected Chair of the England Council of the BGS in 2003. A member of the External Reference Group for developing the National Service Framework he was the geriatrician representative on the National Older People's Task Force. His interests include Day Hospitals, Intermediate Care and chronic disease management.

As a medical manager and educationalist, he has been interested in induction, mentoring, and the day-to-day application of Clinical Governance. In 2002 he was elected as a Director of the British Association of Medical Managers (BAMM) and elected Chair of the Board 2007-9. He was and appointed as an associate member, to the 'Fitness to Practice' directorate of the General Medical Council from 2001-2005.

Previously an Associate Dean with the London Deanery responsible for professional performance in secondary care, he was appointed in October 2004 as Dean Director of Postgraduate Medical and Dental Education for the Kent, Surrey and Sussex Deanery. He is national lead Dean for Medical Oncology, Clinical Oncology and Geriatric Medicine. He is an elected councillor and trustee of the Royal College of Physicians and an examiner since 1999.

An honorary Chair in Medical Education in the Brighton and Sussex Medical School was awarded in 2005.

Tricia Hart

Tricia Hart MA, MHSM, DipHSM, RGN, RM, RHV, CPT, FPCert has been Director of Nursing & Patient Safety at South Tees Hospitals NHS Foundation Trust since April 2005. Her portfolio covers all aspects of professional leadership and governance, including clinical and non clinical risk, as well as patient safety, litigation, complaints, patient and public agenda, bereavement services, adult and child protection. Tricia is also the nominated Board Champion for Children's Services.

In November 2009 Tricia won the NHS Award for Inspiration at the inaugural NHS Leaderships Awards. The aim of the awards is to recognise outstanding leadership in the NHS across England and to encourage and inspire future leaders.

Peter Hutton

Since 1986, Prof Hutton has been Professor of Anaesthesia in the University of Birmingham and Honorary Consultant at the University Hospital Birmingham. As a clinical professor, he has maintained a career mix of clinical practice, research and teaching. From 2000-2003 he was the President of the Royal College of Anaesthetists and from 2002-2004 was Chair of the Academy of Medical Royal Colleges. He is a director of the FH Partnership.

He has worked with the Department of Health and served on a number of public bodies such as the General Medical Council and the Specialist Training Authority and currently sits as the Independent Consultant Member on the Prescription Medicine Code of Practice Authority Appeal Board. He has worked with the government on several aspects of legislation and contributed to the Healthcare Commission, the National Patient Safety Agency, the National Institute for Clinical Excellence, and the National Clinical Assessment Service. He is the recipient of a number of national and international awards for his contributions to medicine.

David Richardson

David Richardson's career in the Police Service spanned 30 years. This included a decade as the Commander of three Police Divisions and also involved the strategic leadership of a Safer Communities Partnership Board and Executive. Following retirement in 2004, David acted as advisor to Government Office, in connection with the improvement of governance and the partnership working arrangements relating to crime, disorder, drugs and alcohol.

David became the Chair of Bradford Teaching Hospitals NHS Foundation Trust in 2005. He is also the Chair of Bradford and Airedale Care Partnerships Ltd, which is a joint venture company involving the public and private sectors and was created to build and manage improved primary care health facilities across the district. He is the Chief Executive of Bradford Breakthrough Ltd, the Senior Business Leaders' Forum for the district, which supports the strategic collaboration of the private, public and voluntary sectors.

The Inquiry also received independent advice on statistical analysis:

Sharon-Lise Normand

Sharon-Lise Normand, Ph.D., is Professor of Health Care Policy (Biostatistics) in the Department of Health Care Policy at Harvard Medical School and Professor in the Department of Biostatistics at the Harvard School of Public Health. Her research focuses on the development of statistical methods for health services and outcomes research, primarily using Bayesian approaches, including causal inference, provider profiling, item response theory analyses, latent variables analyses, multiple informants analyses, and evaluation of medical devices in randomized and non-randomized settings. She is currently President of the Eastern North American Region of the International Biometrics Society. She serves on several task forces for the American Heart Association and the American College of Cardiology, is a consultant to the US Food and Drug Administration's Circulatory System Devices Advisory Panel, and is Director of Mass-DAC, a data coordinating center that monitors the quality of all adult cardiac surgeries and coronary interventions in Massachusetts' acute care hospitals. Dr. Normand has served on several editorial boards including Biometrics, Statistics in Medicine, Health Services and Outcomes Research Methodology, Psychiatric Services, and Cardiovascular Quality and Outcomes. She earned her Ph.D. in Biostatistics from the University of Toronto, holds a Masters of Science as well as a Bachelor of Science degree in Statistics, and completed a post-doctoral fellowship in Health Care Policy at Harvard Medical School. She is a Fellow of the American Statistical Association, a Fellow of the American College of Cardiology, a Fellow of the American Heart Association, and an Associate of the Society of Thoracic Surgeons.

David M. Shahian, MD

In addition to his 25-year clinical career as a cardiothoracic surgeon and Department Chair, Dr. Shahian has been involved with health policy issues for nearly two decades, particularly in the area of performance measurement. As Chair of the Society of Thoracic Surgeons Adult Cardiac Database and its Quality Measurement Task Force, he led development of the STS composite CABG performance measure and the recent extensive revision of its 27 cardiac surgery risk models. Dr. Shahian served on the NQF Cardiac Surgery Technical Advisory Panel and Composite Measure Steering Committee, he was recently elected Vice-Chair of its Health Professionals Council, and he is Chair of its Task Force on Evidence Related to Focus of Quality Measurement. He is a member of the ACC/AHA Performance Measurement Task Force, the ACC Clinical Quality Steering Committee, and the AMA PCPI and its Measure Implementation and Evaluation Advisory Committee. In Massachusetts, Dr. Shahian helped lead the development of the public reporting system for cardiac surgery and PCI, and he currently serves on a state expert panel assessing the use of hospital-wide mortality measures.

Dr. Shahian's research has focused on performance measurement and related health policy issues. Examples include the application of statistical quality control techniques to cardiac surgery; econometric modeling of quality as a factor in selecting cardiac surgery providers; use of hierarchical models for outcomes profiling; clinical versus administrative data for provider profiling; composite performance measures; covariate imbalance and the perils of directly comparing indirectly standardized 'risk-adjusted' outcomes; alternative approaches to outlier determination; and the volume outcome association.

Dr. Shahian holds dual appointments in the Department of Surgery and the Center for Quality and Safety at the Massachusetts General Hospital and he is on the faculty of Harvard Medical School.

Appendix 4

Organisations who submitted material

The Patients Association

Public Concerns At Work

The Royal College of Surgeons

The Royal College of Physicians

The Royal College of Anaesthetists

The Royal College of Nursing

The Royal College of Obstetricians and Gynaecologists

The College of Emergency Medicine

The King's Fund

The League of Friends of Cannock Community Hospital

The Doctor Foster Research Unit, Imperial College School of Medicine

Appendix 5

Background information regarding cases that were brought to the Inquiry's attention

Individuals contacting the Inquiry	
Members of the public	
Members of the public who contacted Inquiry with concerns	691
Members of the public who contacted Inquiry with only positive comments	275
Total	966
Current and former staff members*	
Doctors	22
Nurses	27
Other	33
Total	82

*The figures are staff that the Inquiry heard written and oral evidence from. The Inquiry has also heard from a number of staff through engagement sessions held at Stafford Hospital.

Gender of patients who experienced unsatisfactory care	
Male	310
Female	361
Unknown	27

Number of concerns by ward	
A & E	183
EAU (Emergency Assessment Unit)	53
Ward 7	17
Ward 8	18
Ward 10	34
Ward 11	19
Ward 12	15
Other (Not specified)	358

Date of when unsatisfactory care occurred**	
January – June 2005	27
July – December 2005	30
January – June 2006	45
July – December 2006	34
January – June 2007	39
July – December 2007	61
January – June 2008	72
July – December 2008	68
January – March 2009	40
April 2009 – Onwards	46

**Not all correspondence specified a date when the concerns arose.

Information from third parties***	
Number of cases whose concerns were raised through CURE the NHS	89
Number of cases which were subject to an Independent clinical review	141
Number of cases whose concerns were raised through their local member of parliament	107

***Where evidence has been received from third parties such as the Independent clinical review and local Member of Parliament, the Inquiry has sought the permission of the individuals involved to obtain their information and review their records.

Appendix 6

Essence of Care benchmarks

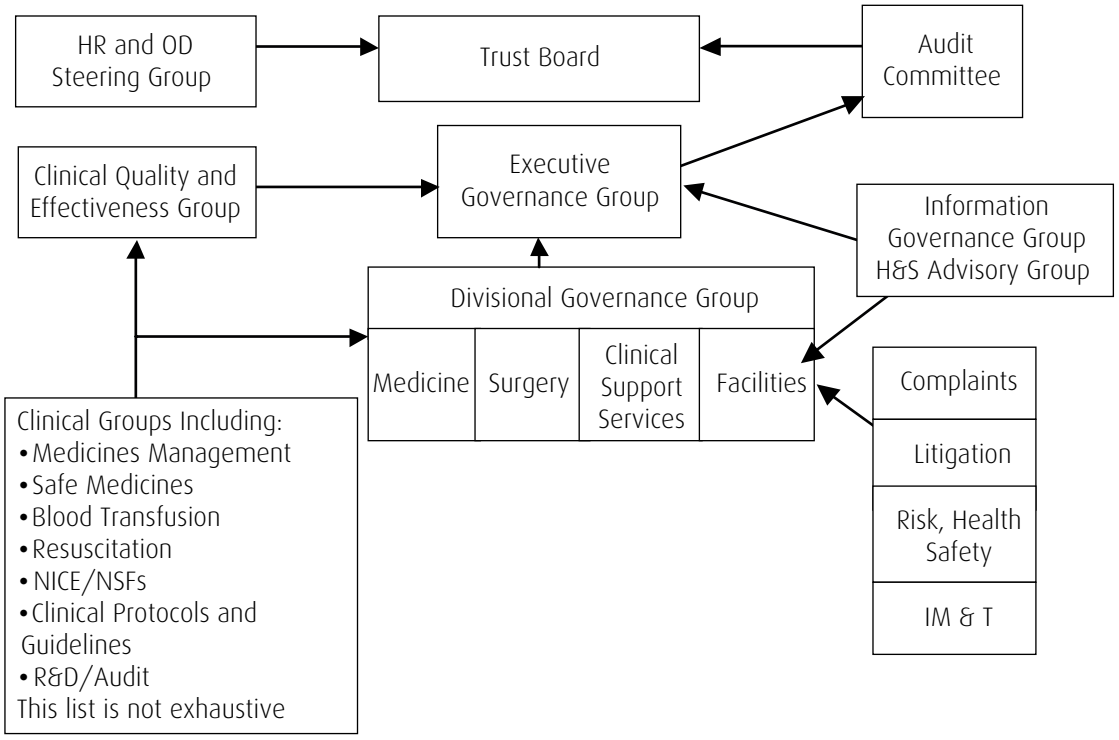
The *Essence of Care* benchmarks were launched in February 2001 to provide a tool to help practitioners take a patient-focused and structured approach to sharing and comparing practice. They were revised in 2003 to include 9 sets of benchmarks, each based around a patient-focused outcome that expresses what patients and or carers want from care in a particular area of practice. Further benchmarks were published on Promoting Health (March 2006) and the Care environment (Nov 2007) and in 2009 the Department of Health launched a review of the benchmarks. The topics and outcomes covered in the 2003 edition of *Essence of Care* referred to in this report are set out below.

Patient Focused Benchmarks for Clinical Governance (2003)

• Communication between Patients, Carers and Health Care Personnel	• Patients and carers experience effective communication, sensitive to their individual needs and preferences, that promotes high quality care for the patient
• Continence and Bladder and Bowel Care	• Patients' bladder and bowel needs are met
• Personal and Oral Hygiene	• Patients personal and oral hygiene needs are met according to their individual and clinical needs
• Food and Nutrition	• Patients are enabled to consume food (orally)
• Pressure Ulcers	• The condition of the patients' skin will be maintained or improved
• Privacy and Dignity	• Patients benefit from care that is focused upon respect for the individual
• Record Keeping	• Patients benefit from records that demonstrate effective communications which support and inform high quality care
• Safety of Clients with Mental Health Needs in Acute Mental Health and General Hospital Settings	• Everyone feels safe, secure and supported with experiences that promote clear pathways to well being
• Self-Care	• Patients have control over their own health care

Appendix 7

The Trust's governance committees



Appendix 8

Cure the NHS's Analysis of Quarterly Complaints Reports 2005-09

YEAR/ QUARTER	NO OF COMPLAINT LETTERS (NO. OF COMPLAINTS	TOP THEMES	OTHER COMMENTS
2005 – July, Aug, Sept.) Q2	96 (Formal Complaints)	Failure to deliver basic standards of nursing care.	Action plan for review of nursing care on W11,12. Implementation of 'Essence of Care' Implementation and monitoring of 'Essence of Care' plan
2005 (Oct., Nov., Dec.) Q3	100-168 (Formal Complaints)	Failure to deliver essential standards of nursing care. Note: "This is an ongoing concern and the numbers of complaints received from medicine and surgery have increased."	(There is contradiction between the 2 reports one identifying 100 complaints the other 168.)
2006 – (July, Aug, Sept) Q2	83 (159)		No actual report (data taken from Q3 06 Report)
2006 – (Oct, Nov., Dec) Q3	78 (155-160)	Standards of nursing care, cleanliness, communications and staff attitude	Goes to Trust Board (first since 03) (Again there is contradiction and error in the reporting)
2007 – (Jan, Feb., March) Q4	94 (141)	Cleanliness, infection control, standards of care, communications and privacy/dignity, staff attitude	Planned introduction of the Voices in Action Network (VIAN) – part of the Individual Voices for Improvement (IVI)
2007 – (April, May, June) Q1	75 (159)	Attitude, communications, transfer arrangements, basic standards of care	A&E dept. very much the focus of complaints (18) – Note: "A&E have seen a dramatic increase in formal complaints".

YEAR/ QUARTER	NO OF COMPLAINT LETTERS (NO. OF COMPLAINTS	TOP THEMES	OTHER COMMENTS
2007 – (July, Aug., Sept.) Q2	85 (129)	Attitude, communications, cleanliness, delay	Another increase in complaints re: A&E dept. (28) 85% of PALS contacts had been seeking advice/ assistance
2007 – (Oct., Nov., Dec.) Q3	92 (118)	Delay in assessment (A&E), communications, staff attitude, delays/cancellation in admissions, transfers, etc.	Increase in complaints re: A&E – explained as result of refurbishment to dept.
2008 – (Jan, Feb, March) Q4	87 (104)	Communications, privacy and dignity, delay in treatment, misdiagnosis	"Complaints about wards 10 and 11 have been of some concern over recent months".
2008 – (April, May, June) Q1	82 (124)	Attitude, communications, privacy/dignity, cleanliness, failure to follow procedures	Complaints in A&E rising again – due to waiting times.
2008 – (July, Aug., Sept.) Q2	84 (170)	Communications, attitude, delay in admissions (A&E), and medical care.	First Action Review Panel met: Identified lack of communication with doctors, failure to track patient records, patients (not) being given assistance with meals/drinks, general communications with patients/relatives
2008 – (Oct., Nov., Dec) Q3	104 (170)	Attitude, communications, missed diagnoses, medical care, delay in admissions.	
2009 – (Jan., Feb., March) Q4	130 (194)	Medical care, staff attitude, delays in treatment, privacy/dignity, missed diagnoses, cleanliness, and medication error.	A&E Dept. receiving significant numbers of complaints again (28).

Appendix 9

Mortality statistics report

1. In July 2009, the Secretary of State for Health, Andy Burnham, announced that an Independent Inquiry (Chaired by Robert Francis QC) would investigate the care provided by Mid Staffordshire Foundation Trust between 2005 and March 2009. As part of this Inquiry, we have been asked to comment on a number of issues related to the performance of the Mid Staffordshire Trust. In this context, we will specifically address the following questions:

    - Were the Dr Foster and internal HCC/CQC statistical mortality analyses conducted in a scientifically acceptable manner?
    - In aggregate, was the overall strength of evidence sufficient to justify the subsequent investigation by the Healthcare Commission (HCC) and its successor, the Care Quality Commission (CQC)?
    - Were the concerns raised by two subsequent University of Birmingham reports (sanctioned by the NHS West Midlands Strategic Health Authority) of sufficient merit to discredit these statistical 'warning flags'?
    - Was the HCC/CQC investigation conducted in a thorough and objective fashion, and did the results of this investigation corroborate the statistical findings?
    - What lessons might be learned from this experience regarding the monitoring of hospital performance?

Were the Dr Foster and internal HCC/CQC statistical mortality analyses conducted in a scientifically acceptable manner?

2. There were two separate and methodologically distinct sets of statistical analyses conducted in parallel. The first was provided by the Dr. Foster Unit at Imperial College, based on a methodology developed by Sir Brian Jarman and associates. The primary reporting format is a Hospital Standardized Mortality Ratio (HSMR), an indirectly standardized ratio of observed to expected mortalities. The expected mortalities are estimated by adjusting for a number of variables including age, sex, admission source, Charlson co-morbidity index, socioeconomic deprivation quintile, primary diagnosis, and a palliative care indicator. It includes all patients encompassed within the 56 diagnostic groups accounting for 80% of mortalities in the reference population. Outlier status is determined using a statistical control chart approach.

3. The parallel internal HCC/CQC monitoring was performed using indirectly standardized mortality ratios based on all patients, comparing a Trust's observed mortality results to what would have been expected based on the national experience for a similar patient mix. Adjustment variables include age, sex, Healthcare Resource Group (HRG), and time period. Z-scores are calculated with allowance for potential over-dispersion using a random effects model and shrinking the most extreme scores.

4. From July of 2007 through November 2008, there were 11 mortality outlier alerts for Mid Staffordshire (HCC Report, March 2009, Appendix E, Table 4) generated by Dr. Foster (6 alerts) and HCC (5 alerts). Seven of these occurred before the initiation of the HCC investigation and 4 subsequent to it. Both the Dr. Foster real-time monitoring system results and the HCC standardized mortality ratios suggested that the number of observed deaths exceeded what would have been expected based on national reference data, and that these aberrant results were largely confined to emergency as opposed to elective admissions (HCC Report, Appendix E, Tables 5-7, Figures 5-6). Because risk standardization is imperfect and the methodology differed between the two monitoring systems, the HCC also computed unadjusted or raw quarterly mortality rates for emergency admissions in three age groups, encompassing three time intervals (2005/2006, 2006/2007, 2007/2008). The Mid Staffordshire rates consistently exceeded national rates with p-values ranging from 0.01 – 0.001 (HCC Report, Appendix E, Table 8). Mid Staffordshire non-standardized mortality also exceeded that of a peer group of nine hospitals from April 2003 to March 2008 (HCC Report, Appendix E, Fig 7 -8). Subsequent analyses investigated the death rates by HRG chapter and specialty, although in many instances the sample sizes were small. Finally, the HCC analysis showed that coding depth (diagnoses per episode) was below the national average in 2006/2007 Quarter 1, but steadily increased so that by Quarter 4 of 2007/2008 their coding depth exceed the English average (HCC Report, Appendix E, Fig 9).

5. It is unfortunate that the figure of 400-1200 excess deaths became so widely publicized and sensationalized. These estimates are derived from 95% confidence intervals around the SMRs, and the intention was to redact them from the final report because of concerns that the public would not understand them. Perhaps a more thorough public educational effort describing the interpretation and limitations of these calculations would have mitigated some of the sensationalism that was subsequently observed. We do not have access to the calculations upon which these estimates are based, nor do we have any reason to disbelieve them. While the absolute numbers may vary slightly depending on what particular statistical technique is utilized, it is clear that the entire 95% range of excess deaths lies well above zero and mandated further investigation.

In aggregate, was the overall strength of evidence sufficient to justify the subsequent investigation by the Healthcare Commission (HCC) and its successor, the Care Quality Commission (CQC)?

6. Unadjusted (non-standardized) mortality rates are rightly criticized for their failure to account for differences in patient severity at different hospitals. Adjusted or standardized mortality rates require sophisticated risk modeling, and different approaches may yield somewhat different results. Notwithstanding these caveats, both non-standardized mortality rates and the results of two different standardized mortality monitoring systems demonstrated that Mid Staffordshire's results were distinctly different from the rest of England. Although one can debate the nuances of any statistical model, both the standardized mortality ratio approaches used are generally consistent with accepted statistical practice. We believe that in aggregate, *the consistently unfavorable results of these non-standardized and standardized mortality ratios would compel any responsible regulatory agency to immediately institute a detailed clinical investigation, as was performed in this case*. It is unfortunate that the Trust (including its Board) were either unaware of these excessive mortality rates before the HC investigation or chose to disregard them, and when finally confronted by the HCC continued to argue for some time that this was a coding rather than quality of care issue.

Were the concerns raised by two subsequent University of Birmingham reports of sufficient merit to discredit these statistical 'warning flags'?

7. Two reports on this subject were issued by the University of Birmingham, having been commissioned by the NHS West Midlands Strategic Health Authority. It is clear from both the content and tone of these reports that they used the Mid Staffordshire controversy as a context in which to critique the Dr. Foster methodology. We will not become part of this debate and restrict our comments to addressing the specific concerns raised by the authors.

June 2008 Report

8. *Clinical Coding*. The HCC report of March 2009 noted that in 2006/2007, coding depth (diagnoses per episode) at Mid Staffordshire was below the English average, but that by late 2007/2008 it had surpassed the average. The report notes the generally poor systems for data collection and coding at the Trust, as well as staffing issues in the coding department. Subsequent audit by the CHKS in 2007 confirmed coding deficiencies, although the audit summary we were provided are not at the level of granularity (e.g., an extensive sampling of coding accuracy for each important covariate in the risk models) that would enable us to estimate their impact on the SMRs.

9. The Birmingham report investigates the hypothesis that under-coding of co-morbidities led to underestimation of expected mortality, and thus overestimation of SMR at some hospitals such as Mid Staffordshire. Although they correctly describe the theoretical potential impact of under-coding, it is unlikely that this phenomenon completely explains the increased risk-standardized mortality at Mid Staffordshire. Furthermore, the maintenance, certification, and submission of accurately coded data to regulatory authorities are ultimately the responsibility of Trust leadership.

10. Finally, although we concur with the general principle that under-coding of co-morbidities may lead to spuriously high SMRs, specific aspects of the author's arguments are less persuasive. For example, they point out that the lowest SMR hospital (UHN) had both the highest mean Charlson index and coding depth, yet it also had the lowest crude mortality and length of stay, and average readmission rate. They conclude that the low SMR at UHN "*did not appear to reflect genuine differences in case-mix profiles*", but rather more complete coding practices compared with other hospitals. They do not acknowledge the other plausible explanation, namely that UHN provided superior care (low crude mortality, SMR, and length of stay) even though caring for sicker patients with more extensive co-morbidities.

11. The authors demonstrate that coding depth and Charlson index increased over time, and that there were parallel reductions in the SMRs, a perfectly logical and intuitive observation. The authors also posit that the establishment of special admitting procedures for emergency patients led to an increase in zero length of stay admissions, that such patients are "*unlikely to be clinically high risk*", and that this also contributed to falling SMRs over time. While this may be true, it is dependent upon whether patients who die on the day of admission and discharge are included in the zero length of stay category. If they are (and we do not have access to this coding specification), then these patients might actually be the sickest patients of all. Moreover, the increase in zero length of stay admissions could also reflect a strategy of transferring patients out when death appears imminent. These various hypotheses warrant further investigation.

12. *The Place of Death Hypothesis*. The authors correctly note that when only considering in-hospital mortality, acute care hospitals with fewer discharge options in the community (nursing homes, hospices, etc., generically referred to as Non Acute Communal Establishments [NACE]), are disadvantaged when computing SMRs. More of their patients will die in the acute care hospital and will be included in their mortality rates, as compared with hospitals whose patients are discharged to extended care facilities and die there. This phenomenon has been recognized for over 150 years since the original epidemiological studies of Florence Nightingale, and it is one important reason that mortality should ideally be measured at pre-specified times regardless of venue (e.g. 30-day mortality).

13. However, in the case of Mid Staffordshire Hospitals, our interpretation of Tables 5 and 6 in the authors' report does not appear to support the argument that this was a major factor in their high SMRs. In Table 5, Mid Staffordshire Hospitals had the second lowest percentage of regional acute care hospital deaths occurring in the dominant provider hospital. Even more importantly, Table 6 shows that between 2003 and 2005, patients in the South Staffordshire PCT (served by Mid Staffordshire Hospitals) had proportions of death in acute hospitals, NACE facilities, and home that were quite close to the West Midlands averages.

14. Of note, in Figures 6 and 7 in this section, as well as in other Figures throughout both the Birmingham documents, the authors refer to "*least squares regression*". They should clarify that this is weighted least squares regression. Likewise, in computing correlation coefficients, all statistics need to be weighted by the number of cases at each trust given the varying sample sizes.

15. *The "Failing" Organization Hypothesis*. The authors argue that if Dr. Foster SMRs are a valid measure of quality, high SMRs should be accompanied by parallel evidence of organizational dysfunction. Their studies of SMRs in conjunction with national survey data suggest "*weak evidence of a non-causal link between SMRs and staff and patient survey variables, suggesting that the links between organizational factors and SMRs are ambiguous*." They did, however, note a much stronger association between staff survey results and patient mortality in the West Midlands than nationally.

16. While interesting from an academic standpoint, these rather neutral overall findings neither discredit the SMR as a measure of patient care quality nor do they shed any light on the situation at Mid Staffordshire. However, the specific findings at Mid Staffordshire (section 5.7, Appendix B) were revealing: "*Mid Staffordshire General Hospitals NHS Trust was in the lowest 10% of trusts nationally for job satisfaction, quality of supervision, and organizational climate, and amongst the highest 20% of trusts for intention to quit*." These findings are quite consistent with the survey and interview findings in the HCC report of March 2009, and other studies in quality and safety would suggest that such staff dissatisfaction may be the substrate for poor performance.

17. We also note that in section 5.6 Appendix A, the Pearson correlation coefficient used to assess the association between bounded variables (such as fractions or percentages) is typically an under-estimate so that, in fact, the pair-wise correlations are likely larger than that reported by the authors. Furthermore, while the authors refer to the Spearman rank correlation coefficient as a "*Robust Correlation*", this measure would not be typically used in the situation the authors have employed it.

18. *Quality of Care Hypothesis*. The authors hypothesize that if SMRs are a valid metric of hospital care quality, then they should provide an assessment of performance that is consistent with the findings of a retrospective clinical review of case records. They studied this hypothesis using two specific tracer conditions—stroke and care of fractured femoral neck—and also low-risk deaths at one hospital.

19. In their stroke analyses, Mid Staffordshire was noted to have a high stroke SMR but relatively good adherence to the designated acute care (<48 hr) process measures. In the femoral fracture study, there was "*no consistent relationship between the quality of care, as described by the process of care indicators in the table, and high/low SMR hospitals*." They conclude that "*there is no systematic relationship between quality of care and SMR. We found that some high SMR hospitals scored well on some aspects of care whilst some low SMR hospitals scored less well on some aspects of care*."

20. The selection of only **two** tracer conditions is an obvious concern, as it represents only a small proportion of a hospital's clinical activity. Accepting this caveat, the findings themselves are not surprising, and they neither explain the results at Mid Staffordshire nor discredit the mortality measurement systems. First, mortality is a crude measure of hospital quality, either overall or for specific conditions. It captures only the most extreme outcome, death, but not the many other potential outcomes that may reflect quality. Second, some of the processes of care measured in this study may not be closely linked with mortality, a finding that has been observed in numerous studies of acute myocardial infarction. The latter has led some to question the value of measuring compliance with optimal care processes as a means of profiling providers. Although their process measures were derived from existing audit tools, no evidence is presented by the authors to show that these selected process measures would be expected to significantly impact patient mortality.

21. The authors also studied mortalities that occurred at the George Eliot Hospital, which had the highest SMR and thus 'excess deaths'. Their review of 'low risk' deaths at George Eliot Hospital suggested "*little or no correlation between a clinically low risk death and the Dr. Foster low risk deaths, suggesting that the latter systematically fails to capture clinical risk adequately and that at least in two-thirds of cases there was no quality of care issue*".

22. This conclusion is not directly related to the situation at Mid Staffordshire. Rather, as with much of the report, it questions the overall credibility of the Dr. Foster system, one of the warning flags that ultimately led to the investigation of Mid Staffordshire. We have numerous concerns with this particular section of the report. First, the definition of Dr. Foster 'low risk' as an expected mortality <10% is problematic, as an 8 or 9% mortality rate would actually be high for many conditions and diagnoses. Second, no definitions or specifications are provided for

the clinical assessment of risk categories used by the case reviewer. Third, even using this problematic approach, in 30% of cases there were areas of concern that may have contributed to the patient's death, of which 40% were hospital acquired infections (primarily Clostridium difficile). In contrast to the authors' findings, we regard this as a significant indication of probable quality of care issues.

23. Based on the preceding comments, we do not believe the authors have presented sufficient credible evidence to support their overall conclusion that "*it is difficult to see how to give a consistent credible interpretation to the Dr. Foster SMR. It appears neither to reflect patient risk nor quality of care reliably*".

24. *The Constant Risk Fallacy*. The authors again focus their attention on the validity of the Dr. Foster methodology by asserting that it is seriously flawed due to the 'constant risk fallacy'. This occurs, according to the authors, when the relationship between a particular risk factor and outcome varies substantially among hospitals. They studied this problem using data from four West Midlands Hospitals.

25. Although we agree with the potential concern expressed by the authors, we believe that much of the apparent "constant risk fallacy" is, at least in their study, related to the coding issues discussed previously. It is true in general that risk models derived from one population may need to be recalibrated for optimal performance in an entirely different population, and this may reflect differences in how risk factors impact outcomes. However, among a group of 4 hospitals in the West Midlands, there are unlikely to be such differences. Instead, the "constant risk fallacy" described by the authors in this specific instance is most likely related to differences in the accuracy and depth of coding discussed previously, both of which impact Charlson index and SMR. These issues are the direct responsibility of the Hospital administration and are not an issue with the Dr. Foster system.

26. We are disturbed by the final sentence summarizing the author's conclusions: "*In other words, quality of care should remain innocent until proven guilty*". This is a hospital-centric admonition, but certainly not one that would be acceptable to most patients or to the regulators entrusted with ensuring the quality of their care. We accept that there is no single, perfect mechanism for assessing health care quality. We also agree that every statistical quality monitoring algorithm, including Dr. Foster, should be critically examined by experts to determine its validity. However, we believe that in the case of Mid Staffordshire, there were so many different warning flags from different entities, using different approaches, and over multiple time periods, that it would have been completely irresponsible not to aggressively investigate further.

Was the HCC/CQC investigation conducted in a thorough and objective fashion, and did the results of this investigation corroborate the statistical findings?

27. In our opinion the indications for an extensive review of Mid Staffordshire were unequivocal. Furthermore, in addition to considering the statistical outcomes, the breadth and depth of the HCC on-site review were commendable. They conducted patient and staff interviews; reviewed case notes; evaluated structural, process, and staffing issues associated with poor outcomes; and identified numerous significant leadership failures. The latter included an apparent focus on financial savings to the detriment of quality; insufficient attention by clinical leaders to real-time quality monitoring and continuous improvement; initial attribution of high SMRs to coding, with inadequate consideration that there might be true quality issues; lack of adequate 'reporting-up' to the board level; excessive board secrecy about quality concerns; and global leadership failure to regard quality as the dominant institutional priority.

What lessons might be learned from this experience regarding the monitoring of hospital performance?

28. As in the US, media sensationalism did not contribute in a positive way to the investigation and resolution of the Mid Staffordshire quality concerns. Furthermore, 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. We make no overall judgments about the latter, as this is better done outside the context of a specific hospital review. In this instance it was only one of a number of lines of evidence that led to the Mid Staffordshire investigation, and it appears to have correctly issued a warning flag about a potential quality problem.

29. We believe that the findings and recommendations of the HCC report speak for themselves and are completely appropriate. Their investigation was initially prompted by multiple lines of statistical evidence suggesting poor quality. They undertook a detailed on-site evaluation, as described previously. We concur with their comprehensive report recommendations and have added a few additional ones below based on our experience administering a public reporting system for CABG and PCI in the Commonwealth of Massachusetts:

- Institutions must systematically and continuously monitor their performance across a wide range of conditions and procedures. The results of such ongoing assessments must be reported up through successively higher levels of leadership, ultimately including comprehensive and transparent presentations to the Board. Board responsibility for all aspects of hospital quality should be firmly established through regulatory statute or legislation, and this domain of their responsibility should be viewed as equally or more important than their financial accountability.
- Healthcare data accuracy is critical, particularly in a public reporting or pay for performance environment. Leadership must commit sufficient resources to both coding and audit, they should systematically review the accuracy of their data, and they should accept without excuse or denial the results of external analyses based upon the data whose release they authorized.
- Overall mortality rates are a very high level metric, and a satisfactory overall SMR can actually obscure suboptimal performance in specific areas. They should always be interpreted in association with results for a more focused portfolio of condition and procedure-specific metrics. The latter may include not only mortality but also morbidity and compliance with accepted, evidence-based care practices.
- Some differences in mortality among hospitals result not from their quality of care but rather from their ability to discharge patients to extended care, non-acute facilities in their community or region. These inequities may be mitigated by calculating mortality at some definite time interval, such as 30-days, regardless of venue, rather than using in-hospital mortality.

- Both data analysts and regulators should be engaged with providers on an ongoing basis, not just when an investigation is necessitated by outlier status. This may facilitate greater provider acceptance of the quality monitoring program. Opportunities include:
  - Continuous feedback to providers regarding data quality, including risk factor distributions and missing data frequency—this should include opportunities to correct errors
  - Regional provider collaboratives may provide an opportunity for hospitals to adjudicate coding differences and develop best-practice quality improvement initiatives
  - Hospitals should be notified not just when they are identified as outliers, but when their results are trending in an unfavorable direction or are close to outlier status.

- Finally, hospitals should recognize that not being classified as an outlier is no reason for complacency. All hospitals should constantly strive to improve their own performance, regardless of their current level of performance relative to other programs.

Respectfully submitted,

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Bibliography

- *Investigation into Mid Staffordshire Foundation Trust*, Healthcare Commission (2009)
- *Mid Staffordshire Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report*, Professor Sir George Alberti (2009)
- *A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation*, Dr David Colin Thomé (2009)
- *Report of a clinical governance review at Mid Staffordshire General Hospitals NHS Trust*, Commission for Health Improvement (2002)
- *Investigation into outbreaks of Clostridium difficile at Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust*, Healthcare Commission (2006)
- *Spotlight on Complaints*, Healthcare Commission (2009)
- *Notes on Nursing,* Nightingale (1860)
- *High Quality Care for All – Next Stage Review Final Report*, Department of Health (2008)
- *Our NHS, Our Future – Next Stage Review – Interim Report*, Department of Health (2007)
- *Essence of Care: Patient-focused benchmarks for clinical governance*, NHS Modernisation Agency (2003)
- *Looking Forward: Clinical governance and the drive for quality improvement in the new NHS in England*, Scally and Donaldson (1998)
- *A Commitment to Quality, a Quest for Excellence: a Statement on behalf of the Government, the Medical Profession and the NHS*, Department of Health (2001)
- *Clinical Governance Reporting Processes*, Department of Health (2002)
- *Governing the NHS – A Guide for NHS Boards*, NHS Appointments Commission (2003)

- *Code of Conduct for NHS Boards*, Appointments Commission/Department of Health (2004)
- *Code of Conduct for NHS Managers,* NHS (2002)
- *Code of Governance for NHS Foundation Trusts*, Monitor (2006)
- *The Handbook to the NHS Constitution*, Department of Health (2009)
- *The Statement of NHS Accountability*, Department of Health (2009)
- *The NHS Constitution: all you need to know about how the NHS Constitution affects you as a provider or commissioner of NHS care*, Department of Health (2009)
- *The NHS Constitution State of Readiness Group: Final Report,* Department of Health (2009)
- *A simple guide to Clostridium difficile*, Department of Health (2007)
- *Clostridium difficile infection: How to deal with the problem*, Department of Health and Health Protection Agency (2008)
- *Making a Difference – Strengthening the nursing, midwifery and health visiting contribution to health and healthcare,* Department of Health (1999)
- *Freedom of speech in the NHS*, Department of Health Circular (2007)
- *Clinical Exceptions to the 4 hours target,* Department of Health (2003)
- *Good Medical Practice*, GMC (March 2009)
- *Principles of Good Complaints Handling*, Parliamentary Health Service Ombudsman (2009)
- *Consultation on Sharing and Publishing Information About Complaints*, Parliamentary Health Service Ombudsman (2009)
- *Patient Safety – 6th report of session 2008-09,* Health Select Committee (2009)
- *Whistleblowing: Advice for BMA members working in NHS secondary care about raising concerns in the workplace,* BMA (2009)

- *Probing variations in hospital standardised ratios in the West Midlands*, Mohammed and Lilford (2008)
- *Alcohol Rub, Inferior Wipes Inferior at Removing Clostridium Difficile, report of 47th Annual Intescience Conference of ICAAC,* Medscape Medical news 21 September 2007
- *NHS targets 'may have led to 1,200 deaths' in Mid-Staffordshire*, Daily Telegraph (18 March 2009)
- *Alan Johnson moves to 'close this regrettable chapter in hospital's past',* Guardian (17 March 2009)
- *Evidence of methodological bias in hospital standardised mortality ratios: retrospective database study of English Hospitals*, Mohammed et al, BMJ 2009:228;780
- *Bosses to blame for "Third World" hospital Mid Staffordshire NHS Foundation Trust* Times, 18 March 2009
- *Brown apologises for unacceptable failings at Stafford "Third World" hospital"*, Daily Mail 19 March 2009
- Public Bodies (Admissions to Meetings) Act 1960
- Employment Rights Act 1996
- Local Authority, Social Services and National Health Service (Complaints England) Regulations 2009