Robert Francis QC Mid-Staffs Inquiry Report

1. The long awaited above report was finally published on 24th February. NGH had already started a series of projects to assess our position against initial indications arising from the events in Mid Staffs. The projects that were originally commissioned were :-

    a) Emergency Care Pathway and Escalation
    b) Registrar involvement in the care of acutely ill patients
    c) Consultant involvement in the care of acutely ill patients
    d) Physiological Observations
    e) Out of Hours diagnostics and therapeutic intervention Gap Analysis Group
    f) Critical Care review
    g) Night team Working Group
    h) Handover between shifts
    i) Workstream
    j) The Medical Notes and Clinical Coding
    k) Accident & Emergency / Emergency Admission Unit Medical Equipment

2. Sonia Swart and I will review the progress of each of these projects and bring the recommendations of them to the Board.

3. We must now review in totality the final report and look to see whether there are further lessons for us to learn, and if there are, ensure that we have effective actions in place in order to ensure that we do not let our patients down in the same way as occurred in Mid Staffs.

4. The majority of the findings related to the patient experience rather than delivery against targets. Indeed, Robert Francis's final paragraph in his covering letter to the Secretary of State says "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." In particular he had grave concerns in respect of:-

    - 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.

5. It is worth reminding ourselves of the particular concerns raised against each of these headings :-

5.1 Continence and bladder and bowel care

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.

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.

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.

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.

5.2 Safety

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.

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.

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.

5.3 Personal and Oral Hygiene

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.

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.

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.

5.4 Nutrition and Hydration

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.

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.

5.5 Pressure area care

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.

5.6 Cleanliness and infection control

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.

5.7 Privacy and dignity

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.

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.

5.8 Record keeping

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

5.9 Diagnosis and treatment

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.

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.

6.0 Communication

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.

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.

6.1 Discharge management

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.

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 report concluded that a considerable problem within Mid Staffs was due to the culture that operated within the organisation. 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

7. It is my view that we should not only investigate whether we fail against the standards that were found to be so lacking but also to review ourselves against the cultural failings that were identified.

8. One of the failings at Mid Staffs was that the Trust relied on information and reports that were favourable to it for assurance purposes but negative reports were received in a defensive way and argued against. An example of this was the issue of HSMR.

9. I believe that we should agree upfront how we intend to assure ourselves and not seek evidence to prove that we do not have issues. I would welcome discussion as to how best we approach this.