1 INTRODUCTION

Mid-Staffordshire NHS Foundation Trust had responsibility for 469 in-patient beds, across two hospital sites. It employed around 3,000 staff and served a population of 320,000.

In March 2009 the Healthcare Commission published a report which severely criticised the standards of care at Stafford Hospital, one of the hospitals run by Mid-Staffordshire NHS Foundation Trust. The initial investigation was undertaken due to concerns about higher than expected mortality rates in emergency admission; however it uncovered widespread and consistent reports of unsafe, and in some cases inhumane, practices throughout the hospital which are now well documented.

In February 2010 the first independent review was published by Robert Francis QC. Professional standards, local leadership and scrutiny bodies were all found to be inadequate in preventing ‘appalling’ standards of care, and in detecting and dealing with those problems effectively.

Following this first review, Robert Francis was asked to undertake a public inquiry in relation to the failings at Mid-Staffordshire, with a wider remit including consideration of the NHS system as a whole. The period under review in the public inquiry was from 2005 to 2008, and the inquiry report was published in March 2013.

The public inquiry report is lengthy – over 3000 pages, drawn from 352 witness statements, with 290 recommendations. This report summarises the key findings of the public inquiry and raises some discussion points regarding the lessons that can be generalised from.

It is recognised that a summary report of this nature will necessarily miss elements of the detail, however it is anticipate that the summary will act as a catalyst for more detailed consideration of points of specific relevance to the State Hospital. It is with that in mind that the summary below is provided.

2 THE WARNING SIGNS

With the benefit of hindsight, many warning factors were present in the years before the extent of the failings at Mid-Stafford were uncovered.

Significant issues included:

- Loss of star rating – in 2004 the Commission for Health Improvement reduced the Trust’s rating from three stars to zero. The reasons for this reduction included failure to meet targets for elective surgery, outpatient clinics, cancer treatment and financial performance. The Trust explained this as due to poor record keeping.
- Peer-reviews in 2005 and 2006 raised serious concerns about the Trust’s ability to provide safe and effective care, and raised questions about management capability. It was unclear who had responsibility for following-up peer-reviews to ensure corrective action was taken.
• A Healthcare Commission national review of children’s’ services identified that the Trust did not meet reasonable expectation of patients and the public. The Trust believed this negative report was due to insufficient data being submitted.
• Auditors’ reports raised serious concerns about deficiencies in the Trust's risk management and assurance systems, and called into question the competence of senior management and leadership.
• In-patient surveys showed that patient perceptions were in the worst 20% in the country for many factors.
• Whistle-blowing was ineffective – concerns were not dealt with appropriately and issues raised were not resolved.
• Savings in staff costs were being made to levels which were already known to be deficient, and minimum care standards were not being met.
• The Trust’s application for Foundation Trust (FT) status was largely focussed on financial performance and governance systems rather than quality of care.

3 FACTORS THAT CONTRIBUTED TO POOR STANDARDS OF CARE

Much of the report considers what each organisation linked to Mid-Staffordshire knew, or should have known, about the quality of care at the Trust, and the action that was taken (if any) to address concerns.

• Negative culture – the Trust’s culture was one of self-promotion rather than critical analysis and openness. The Board and senior leaders failed to appreciate the enormity of what was happening. They reacted too slowly, if at all, to matters that they were aware of, and played down the significance of others. There was an engrained culture of tolerating poor standards, and a focus on financial targets.
• Professional disengagement - clinicians did not pursue concerns about patient safety with senior leaders. Difficult personnel issues were ignored. The Trust lacked a sense of collective responsibility for ensuring quality care was provided at every level.
• Poor governance - the absence of a functioning, effective clinical governance system meant that the leadership of the Trust was bound to be blind to many concerns. Although in theory systems were in place, no-one checked that those systems were working effectively.
• Insufficient attention paid to quality of service, and inadequate risk assessment of staff cuts – the board was focussed on financial performance to achieve FT status. The economies sought, year on year, were not critically appraised in relation to their impact on patient care. In short, the priorities of the trust were wrong.
• Nursing standards and performance – due to poor leadership, inadequate staffing and poor recruitment and training, a tolerance of poor standards had developed.
• Routes for patient and public feedback were ineffective – surveys were not acted upon. Community Health Councils were ineffective. Public Involvement Forums relied on volunteers with no prior relevant qualifications or experience other than being former patients.
• Failure of organisations with regulatory responsibilities or oversight of performance:
  o Primary Care Trusts (PCTs) – nationally available guidance did not lend itself to more than relatively crude measures of performance, the focus being on financial control and access targets. There was a significant gap between the theory of the PCTs role and their capacity to deliver. The purchaser/commissioning arm of the system was subject to constant reorganisation. During these periods it was assumed that other organisations would have sufficient oversight of performance.
  o Strategic Health Authority (SHA) – there was a lack of clarity regarding the extent to which the SHA was expected to address concerns about quality and safety. Multiple reorganisations resulted in gaps between the PCT and SHA, compounded by mutual misunderstanding about where a function was being performed. There was no system for transferring knowledge from one iteration to the next, in spite of the very substantial cuts to staffing levels. The
SHA took false comfort in from the notion that some potential concerns were not exceptional in Trusts under its control. There was a lack of metrics to measure safety, and outcomes-based measures were replaced with more indirect ones.

- Accreditation bodies with different skill sets did not work effectively together – agencies erroneously awarded FT status without thorough assessment of patient safety and quality standards. Assurances provided by the Trust were not challenged.
- The Healthcare Commission (HCC) - as the regulator, the HCC did not prevent or detect the significant failings of Mid-Staffordshire, although it did take the necessary action to fully expose the scandal. Core standards, and the means of assessing compliance with these, were deficient. Generic standards were formulated by the Government, resulting in disengagement of frontline clinicians whose involvement and endorsement was required for the concept to work. The standards produced were confusing and mixed minimum standards with aspirations. Assessment was over-reliant on self-assessment and self-declaration through which deficiencies could pass undetected and without challenge.

- Professional Regulation – In the absence of any direct complaints, the GMC and NMC lacked the means to ensure the public was protected from poor clinical practice. There was insufficient regulation and oversight of medical training.
- Health and Safety Executive – despite the HSE’s broad jurisdiction, there is a gap in what the HSE are able to investigate in healthcare settings. This resulted in little redress for safety breaches occurring in the hospital by the Health and Safety Executive.

4 WHY FAILINGS WERE NOT DISCOVERED SOONER

The report highlights a number of reasons that problems were not detected and appropriately responded to more quickly:

- The organisation lacked insight, reacted defensively to criticism and lacked openness.
- Regulatory agencies missed, or were unable to follow-up on, warning signs.
- Agencies operated in silos and did not share information and intelligence.
- Regulatory problems were compounded by constant reorganisation resulting in loss of ‘corporate memory’
- Service gaps and communication problems resulted in an over-reliance on assurances given by the Trust. This information was not sufficiently scrutinised.
- Outcomes based performance and risk-based, intelligence-informed regulation were still developing concepts.
- The focus of the system resulted in a number of organisations failing to place patients and quality of care, at the heart of their work.

5 LESSONS LEARNED AND KEY RECOMMENDATIONS

The report raises 290 recommendations, broadly grouped into 29 different themes. These are aimed at a wide range of organisations and many are relevant only to the English systems of care commissioning, accreditation and regulation. However, there are key themes relevant to individual hospitals and health boards regardless of their size, specialty or location, including:

- Healthcare governance – ensuring the focus is not simply on having governance arrangements ‘in place’, but that they are actually delivering the results they are intended to, particularly in monitoring that promised improvements are delivered.
- Culture - the need to put the patient first – within available resources patients must receive safe and effective services from caring, compassionate and committed staff, working within a common culture. There should be zero tolerance of non-compliance of fundamental standards of service.
• Nursing care - refinements to nurse training, education and professional development to focus on the practical requirements of compassionate care and supported by standards for appraisal and support.

• Complaints - listening to patients, staff and the public through effective complaints handling, underpinned by an open culture where concerns are acted upon effectively and swiftly.

• Performance management – refocused on quality, patient safety and patient outcomes, with responsibilities for quality clearly defined, ensuring access to quality and risk data throughout each organisation.

• The need for senior leaders to have greater contact with frontline staff.

6 LOCAL RESPONSE

All Boards have been asked by the Scottish Government to consider the implications of the Francis report for their organisation. Specifically, at the NHS Board Chairs meeting in March 2013, it was asked that boards consider the following questions:

• What is the Board doing to promote a culture which supports the delivery of safe, effective, compassionate and person centred care and ensures openness, transparency and candour?

• How does the Board measure and monitor the safety and quality (including care and compassion) of the services it provides?

• How can the board demonstrate that it acts upon information suggesting that care has fallen below standard in an area?

• What changes of support would you wish to see put in place at national level to help deliver this agenda.

The responses below summarise existing arrangements in response to each of these questions.

QUESTION 1 - What is the Board doing to promote a culture which supports the delivery of safe, effective, compassionate and person centred care and ensures openness, transparency and candour?

The Board has robust arrangements for monitoring the delivery of safe care through risk management and clinical audit. There is a strong culture of incident reporting. Processes and outcomes are monitored by management and governance groups at regular intervals, and escalated where appropriate. Recently implemented improvements to critical incident review processes are aimed at increasing the efficiency and transparency of that process. The hospital is part of the pilot phase of the Scottish Patient Safety Programme for Mental Health and is increasing awareness and participation in this.

Effective care is evidenced primarily via clinical audit and performance management systems. The hospital is currently finalising the first iteration of a scorecard of clinical outcome measures. This includes clinician and patient rated mental health measures, physical health measures, and safety measures.

Compassionate, person-centred care is well embedded within the State Hospital, supported by the national Person Centred Health and Care Programme framework and associated local group. Person-centred care is integral to the clinical model via the Recovery Model, 10 Essential Shared Capabilities and the model’s principles of patient-focussed care, and individualised care pathways. There are a range of patient focus, public involvement (PFPI) structures which support person-centred care, and performance is monitored via a suite of PFPI key performance indicators.

The hospital’s involvement in the Scottish Recovery Indicators (SRI-2) project includes work on service user involvement, promoting a strengths based approach, being recovery focussed, and promoting inclusion. This is monitored via the Realising Recovery Steering Group.
The Clinical Governance Annual Report collates a wide range of metrics to assure the board that safe, effective and person-centred care is being delivered, and is underpinned by efficient and effective processes.

Measuring the organisation’s culture is a challenging task. There are several recent examples where this has been undertaken that are relevant to safe, effective and person-centred care including:

- Multi-disciplinary team-working survey (April 2013)
- Safety climate survey (October 2012)
- Annual patient and carer surveys (December 2012 / May 2012)
- Research studies e.g. Promoting Risk Intervention by Situational Management (PRISM) (2010/11)
- NHS Scotland staff survey (2010).

In addition, in October 2012 an operational review was undertaken by the Chief Executive, who interviewed 10% of a cross section of staff in the hospital. Listening to staff’s experience, and implementing changes in response, is taking us forward with an associated action plan.

**QUESTION 2 - How does the Board measure and monitor the safety and quality (including care and compassion) of the services it provides?**

There is a strong record of measuring and monitoring incidents via the Datix system, with trend reports being shared widely. Local quality improvement and performance management systems capture a wide range of data. Some examples include:

- safety - e.g. incidents, injuries, seclusion and restraint
- effective processes - e.g. integrated care pathway data, engagement in treatment
- perceptions of quality – complaints and patient feedback, patient and carer surveys
- clinical outcomes – medicines management, physical health outcomes, readmission rates, patient reported outcome measures for psychological services.

Work is continuing to expand the availability of clinical outcome measures.

**QUESTION 3 - How can the board demonstrate that it acts upon information suggesting that care has fallen below standard in an area?**

There are many ways that action is taken to address sub-optimal levels of care. As a learning organisation the aspiration is that learning should happen at a system level, although there are occasions when individual performance has to be managed.

Key mechanisms used to identify where system level changes may be required include:

- complaints and patient feedback
- critical incident reviews
- analysis of integrated care pathway variance data
- clinical audit
- external reviews of performance.

The board can demonstrate action has been taken via the minutes of committees and short-life project groups. It can also evidence the effectiveness of the changes made through measurement and re-measurement. Recent examples of system changes made as a result of such information include:

- new approaches to bullying and harassment
- implementing a patient falls pathway
- changes to protocols on the prevention and management of violence and aggression
- changes to electronic patient record standards and processes
- reviewing processes for patient and carer involvement in case reviews
- changes to processes for adverse event management
- changes to infection control precautions.

Whilst the focus of these mechanisms is on systemic improvements, on occasion individual performance issues have been highlighted. There are a range of options to address such issues via human resource procedures, from simply discussing the issue and educating the person involved of the appropriate standard, through structured clinical supervision, to taking formal disciplinary action.

**QUESTION 4 - What changes or support would you wish to see put in place at national level to help deliver this agenda.**

There would appear to be few nationally available, generic resources to support patient safety and quality improvement. It would be valuable to have both basic awareness training packages available, as well as more specialist training.

### 7 MANAGEMENT & GOVERNANCE ARRANGEMENTS

For the benefit of new non-executive directors it may be worthwhile highlighting where information on safe, effective and person-centred care is currently reported and how frequently.

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### 8 OPPORTUNITIES FOR THE FUTURE

The State Hospital has robust monitoring arrangements to ensure safe, effective and person-centred care. However there is always the opportunity to expand improvement efforts.

The development of a local quality strategy may identify additional means of increasing safety, quality and value. This is currently being scoped.

Similarly, current work to expand and roll-out the Scottish Patient Safety programme for Mental Health will support both improvements in patient safety, and further develop a culture of safety and quality.
A significant proportion of data monitoring and quality improvement work is reactive, responding to incidents or recognised areas of sub-optimal performance. There would be merit in looking to expand existing approaches to be more proactive, perhaps looking to larger systems redesign, the reduction of waste, or to improve the ‘untroubling middle’ i.e. processes which are neither exemplar nor causing particular management problems. It is likely that this would increase quality, safety and value.

Finally, maturation and development of systems for monitoring hub-based activities will allow the organisation to better evidence the achievement of the principles identified in the clinical model.

9 RECOMMENDATIONS

The Board is asked to note this position paper, and consider if the opportunities for the future should be further developed to support safe, effective and person-centred care.