2014 HOSPITAL AUTHORITY CONVENTION

7 May 2014

The Mid-Staffordshire NHS Foundation Trust Report
Legal Accountability of Healthcare

Robert Francis QC

Serjeants' Inn Chambers
85 Fleet Street
London EC4Y 1AE

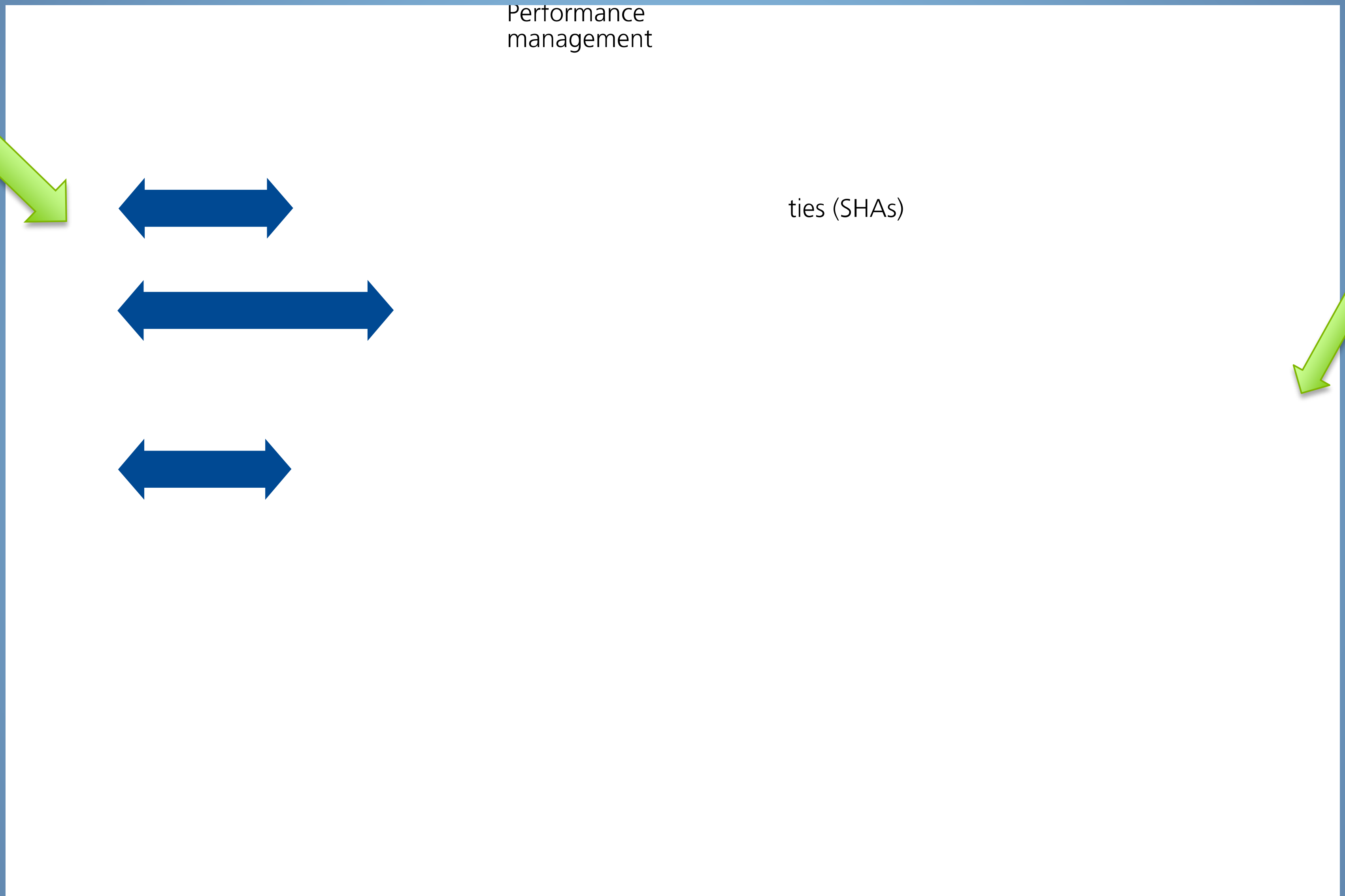
SERJEANTS' INN CHAMBERS

The National Health Service

- Free healthcare at the point of use
- 63.2 million UK residents entitled
- > 1.7 million staff [1.3m in England]
- 1 million patients per 36 hours
- 2013/14 DH budget £114.1 billion
- 2013/14 total budget £339.2 billion
- Health roughly 33% total budget

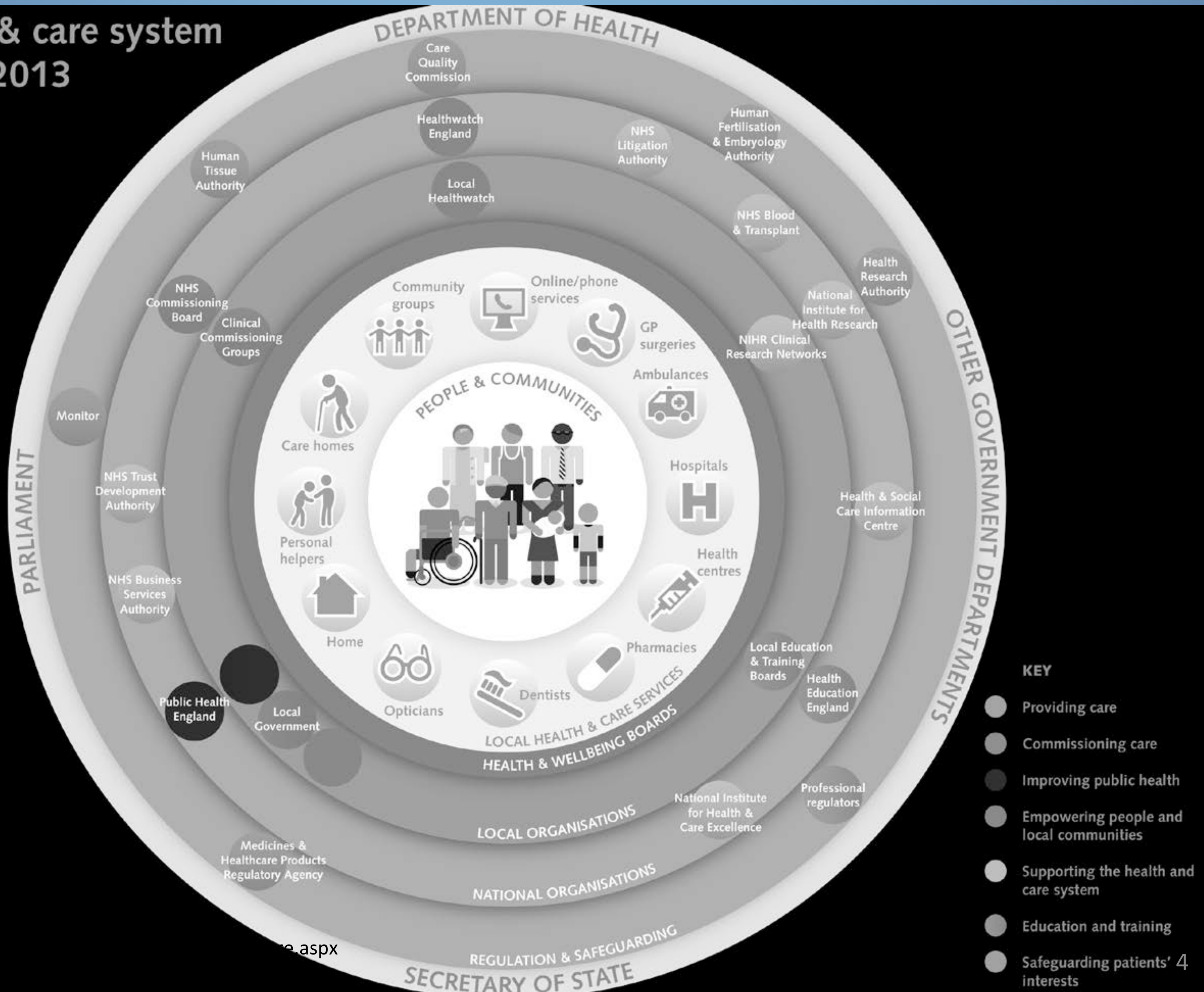
NHS England;
Central Government Supply Estimates 2013-14, April 2013

2005 – 2013: Patients at the edge not the centre



National Quality Board – Review of Early Warning Systems in the NHS, Feb 2010 Structures and processes for safeguarding quality

2014 - Patients at the (soft?) centre



The N
www e.aspx
- dow

System pressures

- Re-organisation
  - PCTs, SHAs, reduced in number
  - HCC abolished for CQC
- Drive for Foundation Trust status
- Cost improvement requirements
- Government access targets
  - A&E discharge times
  - Cancer treatment

The merry-go-round of office

Ministers?

Permanent Secretaries?

Chief executives?

Regulators?

Commissioners?

Directors?

Inquiries?

Staffordshire - Google Maps 14/04/2014 11:16

https://www.google.co.uk/maps/place/Staffordshire/@51.8970446,-1.8002407,8z/data=!4m2!3m1!1s0x487a72c32cd0f2c1:0xd3150c0377a04e08 Page 1 of 2

The hospital

Union reps office

CEO office

Cooling towers–
Badenoch Inquiry
1986

Mid Staffordshire NHS [Foundation]Trust

- Two hospitals
- 354 + 115 in-patient beds [2008]; 301 + 52 [2013]
- 3,000 employees
- Sees 250,000 patients a year
- 63,000 patients admitted a year
- Local population served; 320,000
- Services commissioned by 2 primary care trusts [2013: clinical commissioning groups]
- Performance overseen by W Midlands SHA
- Quality regulator: Healthcare Commission
- Systems regulator [from 2008[: Monitor

Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Chapter 2; (2013)

Trust finance

Table 2.1: Financial performance of the Trust, 2000/01

	2000/01 £000	2001/02 £000	2002/03 £000	2003/04 £000	2004/05 £000	2005/06 £000	2006/07 £000
Turnover	97,295	88,540	99,021	105,809	113,838	112,722	125,643
Surplus/deficit	28	14	8	(509)	(2,158)	478	1,126

Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry page 196 Table 2.1

- 2003/4: cost improvement programme £1.975 million
- 2004/5: recovery plan - £7.7 million recurrent cost savings {reduction 180 WTE staff]; "brokerage" £1.5 million [3 year loan]
- 2005/6: cost improvement programme £9.599 million
- 2006/7: 8% planned cost reductions [regional average 5%]
- 2007/8: cost improvement programme £4.466 million

Nursing establishment

- Jan 2002: Regulator [CHI] reports staffing levels are low
- 2005: staff cuts planned
- March 2007: Director of nursing recognises insufficient numbers
- July 2007: Board informed shortfall of 102.64 WTE nurses
- March 2008: Board receive nursing review: shortfall 120 WTE. Skill mix 40:60 – should be 60:40

Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry page 215 table 2.3

Safety and Quality Governance: bars to Board receiving the truth

- Board focus on “strategic” not “operational”
- Information to Board
  - Complaints not reported
  - Incident investigations not reported
  - Mortality stats discounted
- Clinical representation
  - 1 doctor, 1 nurse
  - Weak consultants committee
- Reliance on external oversight
  - Star ratings
  - NHSLA ratings
  - FT authorisation
- Staff relations
  - Incident reports re staff shortages ignored
  - Concerns raised by staff discounted

Lack of transparency and candour: some examples

- Misinformation to regulators
  - Told mortality not a problem
  - “Quality is our business”
  - “We are in the premier league now”
- Unfavourable reports not shared
  - A&E incident report for coroner required to be modified and not sent
  - RCS report not mentioned to regulator
- Formulaic responses to complaints and “action plans”
- More weight to favourable than unfavourable data
  - Imrovements in percentage approval lauded but no concrn expressed about numbers represented by the minority percentage
- Inadequate weight given to risk to patients
  - No urgency to correct nurse skill mix and patient/nurse ratio
  - Deficiencies in A&E tolerated
  - No urgent action taken re Royal College of Surgeons report

A report on a whistleblowers complaint

The investigation has found evidence of poor leadership and management and of poor nursing care on Ward 3 … There is a strong view on the Ward that failings are due to the poor staffing levels and therefore excusable. The culture on the ward appears to allow for support of this view … Nobody at directorate/Trust level appears to have taken responsibility for monitoring/auditing to ensure that basic nursing standards/patient care
needs are met … There appears to be a lack of commitment at the highest level in the Trust to tackle these problems

*Barry report **August 2005**: Public Inquiry Report page 68*

… The suffering from neglect

The daughter of a patient in ward 11

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…

Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 page 55 [2010]

An internal lawyer's report
Systemic failure of safety?

A detailed investigation has been undertaken including obtaining information from 14 members of staff and considering a substantial number of documents. The following problems have been identified:

- failure to control diabetes
- failure to administer prescribed drugs
- failure to undertake nursing handovers properly or at all
- failure to complete nursing records adequately or at all
- failure to conduct medical ward rounds properly
- failure to make adequate or proper notes of ward rounds and care plans
- failure to give the patient a diabetic menu
- failure to report this matter as a SUI in a timely fashion
- failure to report to report to the Coroner

Extract from Trust investigation report into a death in April 2007

A report on a whistleblowers complaint

The investigation has found evidence of poor leadership and management and of poor nursing care on Ward 3 … There is a strong view on the Ward that failings are due to the poor staffing levels and therefore excusable. The culture on the ward appears to allow for support of this view … Nobody at directorate/Trust level appears to have taken responsibility for monitoring/auditing to ensure that basic nursing standards/patient care
needs are met … There appears to be a lack of commitment at the highest level in the Trust to tackle these problems

*Barry report **August 2005**: Public Inquiry Report page 68*

A Royal College report
A dysfunctional surgical department

- Surgical Department dysfunctional and lacking effective leadership;

- Colorectal department dysfunctional since 2003.
- No working relationship between surgeons in the team:

... no cohesion within the department ... makes it very difficult for other members of the team to function in a satisfactory way

- Multidisciplinary team meetings compromised by disagreement;
- No departmental protocols on bowel preparation, antibiotic usage and postoperative management;
- Surgeon had little or no insight into the problems over 4 years

Extract from RCS report October 2007.
Public Inquiry report page 111-112

The cost of inaction
RCS report two years later

- Poor judgement and decision-making
- Lack of current knowledge and suboptimal post-op care
- Some care “grossly negligent”.
- The surgical division “dangerous”
- Alternative to immediate urgent action was the closure of the department.

The ... Report refers to so many badly managed cases that it would be difficult to single out any particular surgeon

RCS report 2009. Public Inquiry Report page 1027-1028

Complaints

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.

1st Mid Staffordshire report page 273

HSMR – all deaths: the muffled drumbeat

						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
1999/00	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
1996/7-2007/8					114						

Source: Professor Jarman

Recommendations

- Common values
- Fundamental standards
- Openness, transparency and candour
- Compassionate, caring, committed nursing
- Strong patient centred healthcare leadership
- Accurate, useful and relevant information

What can Boards do?

A few suggestions

- Formulate and insist on patient focussed values
- Celebrate and disseminate best practice
- Use failures in fundamental standards as chance to learn
- Act with proportionate urgency to protect patients from risks from staff, other patients, infection, complications etc
- Value those who raise honest concerns
- Visible Board and clinical leadership
- Listen to patients and staff – personally not just through reports and statistics
- Comprehensible, comprehensive and current information
- Be concerned with complaints
- Involve and develop clinical staff leadership
- Be honest with patients, public and regulators

Openness transparency, candour

- Every healthcare organisation and everyone working for them, or on their behalf, must be **honest, open and truthful in all dealings with patients and the public**.
- **Organisational and personal interests** must never be allowed to outweigh the duty to be honest, open and truthful.
- Where harm has been, or may have been, caused to a patient by an act or omission of the organisation or its staff, the **patient should be informed** of the incident, given full disclosure of the surrounding circumstances and be offered appropriate support.
- **Full and truthful answers** must given to any question reasonably asked by or for a patient about treatment.
- Any required statement to regulators or commissioners must be **completely truthful and not misleading by omission**.
- Any **public statement** made by a healthcare organisation about its **performance must be truthful and not misleading by omission**.

Public Inquiry Report page 1491

Candour

- Statutory/regulatory obligation
  - Individual professionals under a duty to inform the organisation or relevant incidents [*codes of conduct]*
  - Healthcare provider organisations under a duty to inform patient of incidents causing "moderate" harm or worse
- Statutory sanction
  - Wilful obstruction of these duties should be a criminal offence
  - Criminal offence of deliberate deception of patients in performing duty
  - *Breach of organisational duty of candour may be prosecuted*
- No censoring of critical internal reports and full information for patients [*"gagging" clauses and requirement forbidden*]
- ?Remedy for patients for non performance of duty of candour [*under review?*]

Fundamentals of care must be obligatory

- I will be cared for in a clean environment
- I will be protected from abuse and discrimination
- I will be protected from harm during my care and treatment
- I will be given pain relief or other prescribed medication when I need it
- I will be helped to use the toilet and to wash when I need it.
- I will be given enough food and drink and helped to eat and drink if I need it.
- If I complain about my care, I will be listened to and not victimised as a result

A New Start , CQC June 2013 p*age* 14

Strong patient centred accountable leadership

- Recruit and train for values
- Leadership by example throughout system
- Code of conduct prioritising patient safety and wellbeing, candour
- Hold staff to account for <u>serious</u> breach and deficiencies
- Provide comparable disciplinary and regulatory accountability for leaders from all backgrounds

Information

- Devise reliable and useable measures of outcomes and performance
  - Including what any patient would want to know
  - Recognise professional responsibility to create and use such measures
- Analyse and present to individuals, teams and units
- Publish individual and team performance fairly
- Act on risks, and look at what has gone wrong

East of England

Trust	Name	GMC	AAA	Open	EVAR	Mortality	Status
Basildon and Thurrock University Hospital NHS Foundation Trust			110	70	40	3.6%	
	Mr Vijay Gadhvi	4714862	39	14	25	0.0%	▲
	Mr Taleb Jeddy	3473959	14	12	2	0.0%	▲
	Mr Kevin Lafferty	2243494	35	22	13	5.7%	▲
	Mr Jay Menon	4258216	40	26	14	5.0%	▲
Bedford Hospital NHS Trust			145	49	96	2.1%	
	Mr Arindam Chaudhuri	4644592	46	11	35	2.2%	▲
	Mr Tapan Mehta	4781923	20	0	20	0.0%	▲
	Mr Nadim Noor	4004778	35	16	19	0.0%	▲
	Miss Debbie Phillips	3310492	17	10	7	0.0%	▲
	Mr Simon Ray-Chaudhuri	3499344	41	23	18	2.4%	▲
	Mr Paul Tisi	3279612	22	7	15	4.5%	▲

www.vsqip.org.uk

Learning from complaints

- *Mid Staffordshire NHS Foundation Trust Public Inquiry Report February 2013]*
  - Make complaints procedures accessible and used
  - Treat concerns raised with same weight as complaints
  - Independent investigation of serious, complex complaints
  - Support for complainants – advocacy, advice
  - Publication of outcomes and anonymised details of upheld complaints
  - Information on complaints to be shared with performance managers and regulators

- *Designing good together: transforming hospital complaint handling. PHSO August 2013*
  - Open culture of feedback and improvement
  - Focus on putting things right on the ward
  - From deferential to collaborative approaches
  - Standardise entry points and branding across all organisations

- *A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture. Clywd/Hart [October 2013]*
  - Information and accessibility: Patients want clear and simple information about how to complain
  - Freedom from fear: Patients do not want to feel that if they complain their care will be worse in future
  - Patients want a response that is properly tailored to the issues they are complaining about
  - Patients want their complaint handled as quickly as possible
  - Patients want their complaints to make a difference
  - Patients want to know the complaints process is independent
- *More Complaints Please! PASC April 2014*
  - "well handled complains can make a difference for both the individual complainant and service concerned"
  - "The importance of leadership cannot be overstated"

Value and protect those who raise honest concerns

- A Stafford nurse:
- *… basically threats to .. my physical safety were made, to the point where I … at night would have to have either my mum or my dad or my husband come and collect me from work because I was too afraid to walk to my car in the dark on my own.*
- People like this need:
  - Easy to understand rules about whether he/she will be protected
  - Protection for public interest disclosures which are based on honest beliefs
  - No adverse consequence if belief turns out to be incorrect
  - Rigorous and immediately available protection from victimisation by employers, colleagues or third parties
  - Effective remedies

Individual professional accountability

- Professionals recognise their duty to patients includes contributing to safe and effective practice by engaging with the administration/leadership
- Professional colleagues and organisations protect patients by sharing and reporting ensure concerns
- Strong leaders do not tolerate unacceptable practice
- Proactive regulators do not wait for specific complaints before investigating

And finally…

2014 HOSPITAL AUTHORITY CONVENTION

7 May 2014

The Mid-Staffordshire NHS Foundation Trust Report
Legal Accountability of Healthcare

Robert Francis QC

Serjeants' Inn Chambers
85 Fleet Street
London EC4Y 1AE

SERJEANTS' INN CHAMBERS