



P R E F A C E.


It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm. It is quite necessary, nevertheless, to lay down such a principle, because the actual mortality *in* hospitals, especially in those of large crowded cities, is very much higher than any calculation founded on the mortality of the same class of diseases among patients treated *out of* hospital would lead us to expect. The

Notes on Hospitals, Nightingale F, 3rd ed 1863, Longman Green Roberts & Green

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Training? Leadership?

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. A visiting relative in 2006



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A patient death

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 SUJ in a timely fashion
- failure to report to report to the Coroner

Extract from Trust investigation report


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It would appear that there were several systemic failures and issues which caused the SUJ to occur in this particular case. Unfortunately, it cannot be said that these failures are an isolated incident and unlikely to re-occur. It is clear from talking to the staff (and examining other medical records) that similar issues are occurring regularly.

Extract from Trust investigation report




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Fear of trouble

- *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.*
- *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.*
- *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.*




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Staff concerns

The wards

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 just skimming the surface and that is not how I was trained.

A nurse




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Staff concerns

A&E

If you are in that environment for long enough, what happens is 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.

A doctor who started in A&E in October 2007




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Disengagement:

The Stafford Way

"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".


Evidence given to the 1st inquiry



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The Terms of Reference for the Public Inquiry were:


To examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner; and appropriate action taken.



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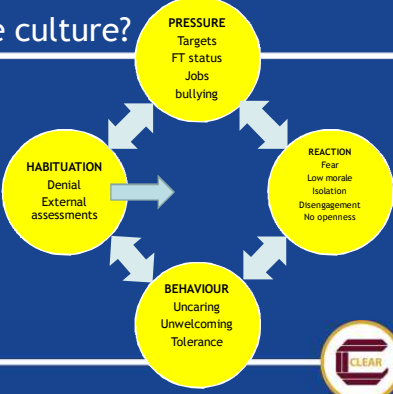
Facts

- Inquisitorial
- 352 witness statements
- 164 witnesses heard in 139 days
- No adjournments
- Inquiry database had 1.2m pages
- 4 volumes to the report



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A negative culture?




PRESSURE
Targets
FT status
Jobs
bullying

REACTION
Fear
Low morale
Isolation
Disengagement
No openness

BEHAVIOUR
Uncaring
Unwelcoming
Tolerance

HABITUATION
Denial
External assessments




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Those who could/should have
picked up the signs

Local “regulation”

- GPs
- Patient and public groups
- Scrutiny committees of local government



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Regulators missing the signs

National regulation - follow the
money!

- Department of Health
- Strategic Health Authorities
- Primary Care Trusts - PCTs
- NHS England
- Clinical Commissioning groups



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Regulators missing the signs

National regulation - follow the
quality!

- Healthcare Commission - self
assessment and inspections
- Care Quality Commission
- Monitor - the financial regulator
- Health and Safety Executive



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Regulators missing the signs

National regulation - follow the professional!

- General Medical Council
- Nursing and Midwifery Council
- Royal College of Nursing
- Royal College of Surgeons
- Universities/deaneries




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Warning signs and the board

An absence of clinical governance - staff

- No systematic appraisal of staff
- No culture of self analysis
- Consultants who wouldn't take guidance
- Isolation and no peer review




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Warning signs and the board

An absence of clinical governance - complaints and information

- Risk register outdated
- SUI's/untoward incidents - lack of knowledge, analysis, follow up, down grading
- Lack of information about the complaints system
- No effective processing of complaints
- Action plans
- Patient surveys
- Staff surveys
- Whistleblowing failures
- Coding/mortality statistics



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An ineffective board


- Lack of experience
- Great self confidence
- No effective clinical or professional voice on the board
- Disengagement of medical staff from management



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An ineffective board


- Lack of openness
- Lack of knowledge of detail - complaints; SUI's, etc
- Tolerance of poor practice - "The Stafford Way"
- An unwillingness to refuse to perform the impossible or dangerous
- Finding excuses



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An ineffective board - Non executives

- Not holding to account
- Wrongly categorising issues of risk to patients as "operational concerns of no strategic significance" - a "false distinction"
- Reliance on assurances which were not checked or challenged
- Closed culture
- Dr Coates: "There was an unwillingness to think that we were doing a bad job"
- An acceptance that having systems was of itself sufficient



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An ineffective board - an isolated focus on finance

- Focus on financial issues, Foundation Trust status, and targets
- No insight into import of decisions on patient care
- FT policy based on an assumption that strong finances would equate to good quality care
- Regulatory severance of finance and quality
- Strong, stable leadership required



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Recommendations

Categories 1-5

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



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Fundamental standards

- What the public see as absolutely essential
- What the professions accept can be achieved
- Enshrined in regulation by Government



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Fundamental standards; *Examples*

- Prescribed medication given
- Food and water to sustain life and well being supplied and any needed help given
- Patients and equipment kept clean
- Assistance where required provided to go to the lavatory
- Consent for treatment obtained



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Fundamental standards; *Sanctions*


- *Isolated incidents*: no tolerance: investigate reasons and correct.
- *Persistent failure* - stop/close the service
- *Death or serious harm caused by breach* - criminal liability for individuals and organisations unless not reasonably practicable to comply



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Fundamental standards; *Guidance*


- NICE to provide evidence based guidance and procedures which will enable compliance with fundamental standards in each clinical setting.
- NICE also to provide evidence based means of measuring compliance.
- Guidance to include measures for staff numbers and skills in each clinical setting required to enable compliance with fundamental standards.



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Category 2
Openness, transparency & candour


- *Openness*: enabling concerns and complaints to be raised freely and fearlessly, and questions to be answered fully and truthfully
- *Transparency*: making accurate and useful information about performance and outcomes available to staff, patients, public and regulators
- *Candour*: informing patients where they have or may have been avoidably harmed by healthcare service whether or not asked



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Openness


- Welcome complaints and concerns
- Gagging clauses to be banned
- Independent investigation of serious cases
- Involving complainants, staff
- Real feedback
- Real consideration by Trust Board
- Information shared with commissioners, regulators, and public
- Swift and effective action and remedies



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Transparency


- Honesty about information for public
- Obligatory balance of information in quality accounts about failures as well as successes
- Independent audit of quality accounts
- Criminal offence of reckless or wilful false statements by Boards re compliance with fundamental standards
- Truth not half truths told to regulators
- Criminal offence to give regulators misleading information deliberately
- CQC to police these obligations



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Candour

- Statutory obligation
 - healthcare provider organisation under a duty to inform patient
 - Individual professionals under a duty to inform the organisation
- Statutory sanction
 - Wilful obstruction of these duties should be a criminal offence
 - Deliberate deception of patients in performing duty should be a criminal offence



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Category 3 COMPASSIONATE CARING COMMITTED NURSING

- Aptitude assessment on entry
- Hands on experience a prescribed requirement
- Named nurse [and doctor] responsible for each patient
- Code of conduct and common training standards for healthcare workers
- Registration requirement for healthcare workers plus power to disqualify/share info re concerns
- Reward good practice; recognise special status of providing care for the elderly



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Category 4 LEADERSHIP


- Cultural “buy in”
- Common code of ethics, standards and conduct for all senior managers and NHS leaders
- Liable for disqualification unless fit and proper person
- Leadership staff college - accreditation scheme
- Mentoring
- King’s Fund Survey 2013
 - 73% say quality of care is inadequately prioritised
 - 40% say NHS leadership is poor
 - 11% say “my team is badly led”



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Category 5
ACCURATE USEFUL RELEVANT
INFORMATION

- Individual and collective responsibility to devise performance measures
- Patient, public, commissioners and regulators should have access to effective comparative performance information for all clinical activity
- Improve core information systems



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LOOK 'EM UP!

Anastasi, John S.									
CABG without Valve	74	49	123	○	○	●	○	○	5.6
Valve without CABG	28	47	75	○	○	○	○	○	7.7
Valve with CABG	19	31	50	○	○	○	●	○	7.7
Total Valve	47	78	125	○	○	○	○	○	7.7
Anderson, John									
CABG without valve	22	5	27	NR	NR	NR	NR	NR	NR
Valve without CABG	15	2	17	NR	NR	NR	NR	NR	NR
Valve with CABG	7	1	8	NR	NR	NR	NR	NR	NR
Total Valve	22	3	25	NR	NR	NR	NR	NR	NR
Anene, Charles									
CABG without Valve	24	21	45	●	●	○	●	○	7.2
Valve without CABG	3	3	6	NR	NR	NR	NR	NR	NR
Valve with CABG	3	3	6	NR	NR	NR	NR	NR	NR
Total Valve	6	6	12	NR	NR	NR	NR	NR	NR
Angelico, Richard J.									
CABG without Valve	49	63	112	○	○	○	○	○	6.1
Valve without CABG	10	7	17	NR	NR	NR	NR	NR	NR
Valve with CABG	11	11	22	NR	NR	NR	NR	NR	NR
Total Valve	21	18	39	○	NR	NR	NR	NR	7.8

* The hospital has informed PHC4 that this surgeon is deceased.

○ Lower than expected ○ Same as expected ● Higher than expected NR - Not rated (too few cases)

PHC4 - Cardiac Surgery in Pennsylvania - 2008-2009

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What's next?
Francis Recommendation 1

“All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work. Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions”.




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The future?

Patients First and Foremost


- All NHS Trusts to hold events to:
 - listen to staff
 - safeguard core values of compassion
- “The NHS and its staff do not need to wait for Government to act to make the aims of the Inquiry a reality. That work can, and must, start now”
- Report back before end of 2013



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The future?


- Patient first
- Fundamental standards
- Statutory duty of candour
- Corporate level criminal sanctions
- Physical inspections by those who know what they are doing



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The future?

- Debarring bad managers
- Debarring bad healthcare workers
- Gagging orders
- Leadership
- At the coal face



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