Summary:
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
Led by Robert Francis QC
&
A promise to learn – a commitment to act: Improving the Safety of Patients in England
Follow-up report by the National Advisory Group on the Safety of Patients in England
Led by Dr. Don Berwick

Introduction

Mid Staffordshire National Health Service (NHS) Foundation Trust provides health care for people in Stafford, Cannock, Rugeley and surrounding areas, servicing a local population of over 276,600. The Trust manages two hospitals at Stafford and Cannock. In June 2010, Robert Francis QC was asked by England's then Secretary of State for Health, the Rt Hon Andrew Lansley CBE MP, to chair a public inquiry into the Trust in response to serious failings that resulted in conditions of appalling care between January 2005 and March 2009. The public inquiry was commissioned to build on a number of previous reports, investigations and inquiries, all of which had failed to satisfy public concerns.

Each of these investigations was highly critical of the care provided by the Trust and described widespread system failure stemming from a lack of governance, poor culture and an environment of staff under constant pressure. Despite countless warning signs – including concerns and complaints from staff, patients and carers as well as unusually high mortality statistics (the mortality rate at Stafford Hospital was 27% above the national average) – problems went unaddressed for a prolonged period of time and hundreds of patients suffered unacceptable harm and indignities. There was also evidence of inaccurate self-declaration and outright fabrication of performance data in order to achieve Trust status from Monitor, the NHS organization responsible for assessing trusts to ensure they are well-led in terms of both quality and finances.

The final report[1] of the public inquiry, which also examines the role of external organizations with oversight of the Trust, was published in February 2013 and includes 290 recommendations. In July 2013 the National Advisory Group on the Safety of Patients in England released a follow-up report[2], the purpose of which was to distil the lessons learned from the public inquiry and specify the changes that are needed.

Discussion

Mid Staffordshire shows complex relationships between governance, performance incentives/facility (Trust) ratings and care delivery. The Trust had the opportunity to reach "Foundation status" by meeting financial and access targets. To achieve these savings, already insufficient staffing levels were further reduced and wards were reconfigured in an experimental and untested scheme. Improperly trained nurses were using vital equipment incorrectly and inexperienced doctors were put in charge of critically

[1] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013. Accessed September 26, 2013 at: http://www.midstaffspublicinquiry.com/report
[2] A promise to learn – a commitment to act: Improving the Safety of Patients in England, July 2013. Accessed September 26, 2013 at: https://www.gov.uk/government/publications/berwick-review-into-patient-safety

ill patients. Misdiagnoses were common. Safety relevant information was not communicated and lines of responsibility were diffused and unclear. Individuals thought to be in charge were not, and in fact, no one was in charge. An environment of neglect was perpetuated and many patients died from avoidable causes or suffered unnecessary harm and indignities.

The organization's strategy to meet fiscal challenges by reducing staff, particularly nursing staff, was found to be a major contributor to the substandard care. This led to other consequences: morale at the Trust was low and while many staff did their best in difficult circumstances, in order to survive others disengaged and showed a disturbing lack of compassion toward patients. Staff who spoke out were ignored or deterred from saying anything at all through fear and bullying. To game access targets, patients were discharged early only to later require readmission. During this time, many patients did not receive the most basic elements of care; they were ignored for lengthy periods and suffered greatly as a result. Patients and their carers felt they could not speak up for fear of reprisal from staff.

The inquiry concluded that deficiencies at the Trust had existed for years and while recognized, were not addressed. Any action taken by the Board was inadequate and lacked the appropriate sense of urgency. The Trust had been so preoccupied with reaching national access targets and financial balance that it lost sight of its responsibility to deliver safe and acceptable care. The mentality of staff and leadership became disconnected from what truly mattered.

Although the inquiry was focused on one organization, it highlighted the broader failures of a system characterized by misaligned goals, misallocated resources, distracted senior leadership and growing opacity. A frustrated and disengaged workforce felt it needed to game data and progress toward goals in order to meet status, fiscal and access targets, and in so doing, disconnected the alarms that were in place to warn of fundamental breaches to patient safety and quality of care. While it would be easy to blame the specific individuals involved – and indeed, many people did lose their jobs – the inquiry and follow-up report by the Advisory Group both found that the problems ran far deeper than any particular group of individuals. In a system that could not "… *be* better, because its people lack[ed] the capacity or capability to improve, the aim [became] to *look* better, even when truth [was] the casualty."[3]

Recommendations

The public inquiry provided 290 recommendations and the subsequent review by the Advisory Group ten. While there is no single way to prevent the tragic events at the Mid Staffordshire Foundation Trust from happening again (in England or elsewhere), the underlying theme of both reports is the fundamental importance of keeping a clear and unfaltering focus on the primacy of patient care and the responsibilities health care organizations and their Boards have to patients, the public and their staff. Some broad themes that emerged from both reports are noted below; for a comprehensive list of all recommendations, please refer to the original documents.

Listen. Patients and carers are an essential asset in the monitoring of safety and quality of care, and must have the opportunity to voice their views and be involved in decision-making around how health care goals can be achieved. Concerns and complaints should be welcomed as valuable feedback for assessing quality and safety within the organization; this relies on openness, transparency and candour

[3] A promise to learn – a commitment to act: Improving the Safety of Patients in England, page 9.

in communication among all parties involved, from frontline staff to senior leadership as well as patients, their carers and the public.

Embrace shared values. The organization and its providers must share the foundational value of putting patients first. Strong, patient-centered leadership is required to protect investments in quality and safety and ensure business does not displace patients as the system's primary focus. Emphasizing common values, and ensuring they are reflected in activities at all levels of the organization, helps to infuse the workplace with pride, joy and compassion rather than fear, anger or apathy.

Own responsibility. Supervisory and regulatory systems should be simple and clear. When responsibility is diffused, no one is in charge and crucial information may not be acted upon.

Tell the truth. Transparency should be complete, timely and unequivocal. Defined mechanisms must be in place to alert staff to problems that put quality and safety at risk. Accurate information about performance should flow freely throughout all levels of the organization and be clearly communicated to providers, regulators, patients and the public. An environment of open communication in which staff, patients and carers are not afraid to speak up should be fostered. The "good" news should never be allowed to excuse the "bad."

Be responsive. Fundamental standards and mechanisms for compliance must be in place. Transparent performance measurement systems that provide accurate, relevant and timely information should be established, with an imperative for leadership to act on information indicating risk. Concerns and complaints should be welcomed and safety issues rigourously investigated. A rigid adherence to strategy should never divorce the Board from knowing the services patients are receiving and the realities of care experiences within the organization.

Be open to change. Sometimes widespread systemic change is necessary. People must recognize when change is required and have the courage to pursue it with clarity of purpose and an unwavering commitment to improvement.

Learn. An ethic of learning must rest at the core of the organization, based on an understanding of quality improvement and patient safety sciences. Concerns and failures should be openly discussed to inform decision-making and improvements. This was identified by the Advisory Group as the single most important lesson for the NHS in response to the failings at the Mid Staffordshire Foundation Trust.

Conclusion

We have much to learn from the events that transpired at the Mid Staffordshire Foundation Trust from 2005-2009. Although the Trust met its financial targets, they were achieved at the expense of patients' basic rights to treatment and dignity. In a system in which quality of care and patient safety were not paramount, it became possible to "hit the target, but miss the point"[4] – and indeed that's what happened. The experience of Mid Staffordshire demonstrates the consequences of ignoring the fundamental responsibility of health care; by placing a primary focus on organizational status, financial and access targets, quality of care and patient outcomes suffered greatly.

[4] A promise to learn – a commitment to act: Improving the Safety of Patients in England, page 8.