Southend University Hospital NHS
NHS Foundation Trust

FTGA National Development Day, Understanding Crises
14 March 2013, in London

Presentation given in person by Robert Francis QC: Lessons from Stafford

This was the 'highlight' of the day for most attendees – even for several 'non-Governor' guests also in attendance. Happily, I found myself sat next to someone I knew - John Coutts, Governance Advisor from the FTN - we were able to chat about general governance / Governor issues in between the sessions.

For those who don't know, my 'local' hospital whilst growing up was Stafford. I've been treated there, both as an emergency admission after a road traffic accident, and also as a day patient. My father passed away at Cannock Chase Hospital – the lessor known hospital making up, together with Stafford Hospital, the Mid Staffordshire NHS Foundation Trust. I was at Stafford Hospital as recently as 16 months ago when a close friend was being treated as an in-patient. And my best friend's husband was one of those to give evidence for the first report regarding the events at Stafford Hospital – his evidence was all positive.

So, I share more than a passing professional interest in Stafford Hospital.

RC began his presentation with a quote from Florence Nightingale, which every nurse must know by heart:

"***What can't be cured must be endured", is the very worst and most dangerous maxim for a nurse which ever was made. Patience and resignation in her are but other words for carelessness or indifference – contemptible if in regard to herself; culpable if in regard to her sick."***
Florence Nightingale, Notes on Nursing (1860) pg 92 - 93

Doesn't that just sum up the whole quality debate, and most of those 290 recommendations?

What was the review about?

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.

There is a tendency when a disaster strikes to try to seek out someone who can be blamed for what occurred, and a public expectation that those held responsible will be held to account. All too frequently there are insufficient mechanisms for this to be done effectively. A public inquiry is not a vehicle which is capable of fulfilling this purpose except in the limited sense of being able to

require individuals and organisations to give an explanation for their actions or inaction. (Report, para 106).

What were the warning signs at Stafford that should have highlighted that something wasn't quite right? The review found the following red flags that should have been noticed sooner:

- Negative patient stories
- Mortality rates
- High incidence of complaints
- Staff concerns
- Information from whistle blowers
- Governance issues
- Finance issues
- Staff reductions

Some of the examples of poor quality care cited in the report were provided, and became more and more distressing with each example provided. The details cited below, were not the worst:
…"…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... "…
(Evidence provided by the daughter of a patient)

In response, the staff felt that they were unable to cope:
…"…I feel ashamed because I have worked there and I can tell you that I have done my best, and sometimes you go home and you are really upset because you can't say that you have done anything to help. You feel like you have not – although you have answered buzzers, you have provided the medical care but it never seemed to be enough. 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 doing – you were just skimming the surface and that is not how I was trained…"
(Evidence provided by a nurse who worked at Stafford Hospital)

…"…The nurses were so under-resourced they were working extra hours, they were desperately moving from place to place to try to give adequate care to patients. If you are in that environment for long enough, what happens is you become immune to the sound of pain. 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, you can't do the best you can…."…
(Evidence provided by an A&E doctor who started there in 2007)

Why wasn't any of this exposed?

- The cumulative effect of concerns was not considered – everything was in isolation
- Lack of support and expertise – by staff, management
- Not listening to patients – did anyone listen?
- Assumptions were made that others were dealing with problems
- Safety relevant information was not communicated
- Barriers had been created to information sharing
- Standards were implemented which missed the point
- Too much of a focus on finance, corporate governance, targets

- Regulatory gaps
- Balancing “bad” news with “good”
- Assuming compliance, rather than fearing non compliance
- Accepting positive information without challenge, and rejecting negative information.

The resulting recommendations that Robert Francis QC put forward, were grouped into themes:

- Compassionate, committed and caring nursing
- Common values
- Fundamental standards
- Openness, transparency and candour
- Strong patient centered healthcare leadership
- Provision of accurate, useful and relevant information
- Culture change which is not dependent on the Government.

Governors at the Trust told the enquiry:

- To be perfectly honest, it was a huge learning curve for everybody and I can’t say that it was an effective body at all and when we gained foundation status, I don’t think anybody, either the Trust or the council of governors, were really clear about their role or how to put it into play.
- When I did ask at one meeting when I was feeling particularly brave or stupid, how this [HSMR] worked, we were told it is very complicated. Everything was always very complicated.
- We were controlled... if we had to put any other business, it had to be two weeks before so nobody ever did. Nobody was encouraged or indeed dared to ask a question.

Finally, some thoughts from me:

If Robert Francis QC came to Southend and asked “what did you do about it?” what would be your answer – after all, Governors now represent the interests of the public at large, not only Members, so there are many to answer to.

‘Hold the NEDs to account’ you might say. But what does that actually mean? Try to provide an example of how you’ve held the NEDs to account this month, either personally or as a group.

Ask yourselves, how does the work of the Governor Groups and Committees (save for the opportunities at NAGG) help the Council to hold the NEDs to account? What is it that the Groups and Committees are hoping to achieve? Do they work in conjunction with each other, ensuring value for money and that none of their work overlaps, or does each have its own agenda which works in a completely separate silo? How effective are those Groups and Committees in achieving their aims? Do they actually know what their aims are, or are resources being used to try to determine this?

Anna Milanec
Trust Secretary