PREFACE.

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
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“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.
Some figures...

- 1 million pages of documentary material
- 250 witnesses
- 139 days of oral hearings
- Terms of reference announced 9 June 2010
- Report handed to Sec of State 5 February 2013
- Costs £13 million to November 2013
- AN Other Inquiry: £40 million before oral hearings....
- 1781 pages
- 290 recommendations
30 minute overview...

- What it was about and not about
- What went wrong in Stafford
- What the system did and did not do
- What needs to be done now
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.

Public Inquiry Report para 106
But who is important?
Spot the town...
Union reps office

CEO office

Cooling towers–Badenoch Inquiry 1986
Warning signs

- Patient stories
- Mortality
- Complaints
- Staff concerns
- Whistleblowers
- Governance issues
- Finance
- Staff reductions
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...
The daughter-in-law of a 96 year old patient

We got there about 10 o’clock and I could not believe my eyes. The door was wide open. There were people walking past. Mum was in bed with the cot sides up and she hadn’t got a stitch of clothing on. I mean, she would have been horrified. She was completely naked and if I said covered in faeces, she was. It was everywhere. It was in her hair, her eyes, her nails, her hands and on all the cot side, so she had obviously been trying to lift her herself up or move about, because the bed was covered and it was literally everywhere and it was dried. It would have been there a long time, it wasn’t new.
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
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 the Coroner
It would appear that there were several systemic failures and issues which caused the SUI 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.
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.

you have rushed the blood through, I said to the sister, and she said, ... I have had to come in and give the blood and don’t moan... because I have had no break today. That’s what she said, and she probably hadn’t had a break. So I didn’t mention the frusemide to her because she was obviously fraught.

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.
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.
I mean in some ways 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.
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.

A doctor who started in A&E in October 2007

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Perhaps I should have been more forceful in my statements, but I was getting to the stage where I was less involved and I was heading to retirement ... I did not have a managerial role and therefore I did not see myself as someone who needed to get involved. Perhaps my conscience may have made me raise concerns if I had been in a management role, but I took the path of least resistance. In addition ... most of my patients were day cases and there was less impact on those patients. There were also veiled threats at the time, that I should not rock the boat at my stage in life because, for example, I needed discretionary points or to be put forward for clinical excellence awards

Evidence given to the Public Inquiry
A negative culture?

**PRESSESURE**
- Targets
- Finance
- FT status
- Jobs

**REACTION**
- Fear
- Low morale
- Isolation
- Disengagement
- No openness

**BEHAVIOUR**
- Uncaring
- Unwelcoming
- Bullying
- Keeping head down

**HABITUATION**
- Tolerance
- Denial
- External reassurance
- Someone else’s problem

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The system’s business not the patients

- GPs
  - Did not look for concerns or pass them on
- Patient and public groups
  - Inward looking
  - Insufficient support or expertise
- Scrutiny committees
  - Did not listen
- PCTs
  - Not equipped to fulfil theoretical duty re quality
- SHAs
  - Did not react to potential safety implications
- DH
  - Insufficient attention to safety implications of reorganisation and targets
  - Insufficient information to minister on concerns about the Trust
Regulators missing what was important for patients

- **HCC**
  - Standards system which missed the point
  - Proved that rigorous expert inspection works

- **Monitor**
  - Focus on finance and corporate governance
  - No check on quality of delivery

- **HSE**
  - Left clinical care to others

- **CQC...**
  - Unhealthy culture
  - Would it spot a Stafford today?

- **GMC/PMETB**
  - Limited view of patient safety
  - Lack of proactivity
Professional and other groups not thinking enough of patients

- RCN
  - Conflict between roles
  - Ineffective support
- RCS
  - Information raising concerns not shared
- University
- Deanery
Recommendations

- Common values
- Fundamental standards
- Openness, transparency and candour
- Compassionate, caring, committed nursing
- Strong patient centred healthcare leadership
- Accurate, useful and relevant information
- Culture change not dependent on Government
Values – clarity and commitment

- Put patients first
  - Staff put patients before themselves
  - Staff do everything in their power to protect patients from avoidable harm
  - Openness and honesty with patients regardless of consequences for themselves
  - Direct patients to where assistance can be provided
  - Apply NHS values in all their work
- Make NHS Constitution the shared reference point for values
- All NHS and contractors to commit to NHS values
What the public see as absolutely essential
What the professions accept can be achieved
Enshrined in regulation by Government
Compliance measured by evidence based methods
Policed by CQC [including governance required to meet these standards]
Distinguish from enhanced quality standards subject to commissioning
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
Fundamental standards

Sanctions

- 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
  - ?Defence for individual to have reported obstacles to compliance
  - Prosecution matter of last resort/serious cases
- Isolated incidents: no tolerance: investigate reasons and correct.
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.
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.
Candour

- Statutory obligation
  - Individual professionals under a duty to inform the organisation or relevant incidents
  - Healthcare provider organisations under a duty to inform patient
- Statutory sanction
  - Wilful obstruction of these duties should be a criminal offence
  - Deliberate deception of patients in performing duty should be a criminal offence
- No censoring of critical internal reports and full information for patients
- Remedy for patients for non performance of duty of candour
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 on actual cases shared with commissioners, regulators, and public
- Swift and effective action and remedies
Transparency

- Honesty about information for public
- Balanced 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 to be told to regulators
- Criminal offence to give deliberately misleading information to regulators
- CQC to police information obligations including information on enhanced quality standards
Compassionate Caring Committed Nursing

- Aptitude assessment on entry
- Hands on experience a prescribed requirement
- Standards of training standards, assessment, appraisal for core values and competence to deliver
- Named nurse [and doctor] responsible for each patient
- Code of conduct and common training standards for HCSWs
- Registration requirement for HSCWs plus power to disqualify/share info re concerns
- Reward good practice; recognise special status of care of elderly
- Review Knowledge & Skills Framework
Recruit and train for values
- Staff college open to all candidates and recruits
- Voluntary accreditation

Leadership by example

Code of conduct prioritising patient safety and wellbeing, candour

Accountability through disqualification for serious breach and deficiencies

Keep possibility of wider regulation under review
ACCURATE USEFUL RELEVANT INFORMATION

- Individual and collective responsibility to devise performance measures [R262-267]
- Patient, public, commissioners and regulators access to effective comparative performance information for all clinical activity
- Improve core information systems
### Look 'Em Up!

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* 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)

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Lessons from Stafford

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