

ITEM: 09/095

DOC: 6

Meeting: Trust Board
Date: 17 June 2009

Title: Lessons from the Healthcare Commission report into Mid Staffordshire NHS Foundation Trust

Executive Summary: Board members will be aware that the Healthcare Commission recently published their findings following an investigation into patient care at Mid Staffordshire NHS Foundation Trust. The summary report has previously been circulated to Board members and can be found at www.cqc.org.uk/publications

The report contained a number of key recommendations, of which some were specific to Mid Staffordshire, and others were for all trusts to consider. The national recommendations included the provision of safety and quality information to trust boards, and standards of care on general wards.

In addition, the Department of Health asked Dr David Colin-Thome, national director of primary care, and Professor Sir George Alberti, national director for emergency care, to undertake local further reviews. The Alberti report looked in more details at the specific problems identified within Mid Staffordshire Hospital, and the Colin-Thome report looked at lessons for the wider health community. Both reports are published on the Department of Health website, and the introduction and summary from the Colin-Thome report are attached to this paper for information.

Performance at the Whittington against the national recommendations from the Healthcare Commission report, and the key findings from the Colin-Thome report has been reviewed, and is summarised in the attached chart. This was discussed at the May Clinical Governance Committee.

In the main, there are no major gaps identified in care at the Whittington. Work is, however, planned or in progress in a number of areas that will provide greater assurance about robust, high quality care for patients in the hospital.

These include:

- developing a more robust procedure for prioritising the theatre order of emergency surgical patients
- recruiting to senior medical posts in the emergency department
- building on the use of patient feedback across the hospital
- recruiting to nursing and midwifery vacancies across the hospital, and so reducing reliance on temporary staff.

Action: for information and discussion

Report from: Veronica Shaw, Assistant Director of Nursing & Clinical Development

Sponsor:	Deborah Wheeler, Director of Nursing & Clinical Development
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Compliance with Care Quality Commission Core Standards Lead: Director of Nursing & Clinical Development	Reference: C1b – learning from incidents and reports
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Review of Whittington position against Healthcare Commission report into Mid Staffordshire NHS Foundation Trust

1. Healthcare Commission Recommendations

HCC Recommendation	Lead	Whittington Position
1. Ensure that the Trust Board has a systematic means of monitoring mortality rates and other patient outcomes that are comparative, accurate, complete and as up to date as possible	David Emmerson	<p>Compliant</p> <ul style="list-style-type: none"> • 2009 published standardised mortality rate reduced to 73, from 84 in 2008. Reported to May 2009 Trust Board. ▪ The trust uses the Dr Foster Intelligence system to track hospital standardised mortality rates ▪ The overall hospital SMR is reported to the Trust Board each month, and as a trend over time (with confidence intervals) and against a peer group ▪ More exception reports go to the Clinical Governance Committee to look at any underlying trends and identify potential areas for further investigation
2. Consider publishing mortality rates in a way that whilst not causing unnecessary alarm to patients, nor lead to clinically adverse behaviour from clinicians, allows patients to make informed choices	Fiona Elliott	<p>Compliant</p> <ul style="list-style-type: none"> ▪ The trust's standard mortality rate is included in the trust dashboard, which is presented to the Trust Board on a monthly basis. ▪ Trust Board papers are available to members of the public via the hospital website. They can also be accessed through Dr Foster's and have been published in local newspapers. See: - <p>http://www.whittington.nhs.uk/deflauly.asp?c=7691&t=1.182 http://www.camdennewjournal.co.uk/2004%20archive?200504/f200504.3htm</p>

<p>3. Ensure that the Trust Board has a focus at all times on the safety and quality of the services provided to patients. This includes having information available about the patient experience</p>	<p>Fiona Elliott</p>	<p>Compliant</p> <ul style="list-style-type: none"> ▪ The trust dashboard includes a performance domain specifically around patient experience. Results of the internal patients survey are presented on a monthly basis. ▪ Additionally there is a clinical quality domain on the dashboard. This is currently being updated to ensure relevance to the “Patient Safety First” campaign. ▪ Patient Safety First campaign presented to Trust Board in March 2009. and is included in 2009/10 trust objectives, led by the Medical Director ▪ Annual patient survey presented to Trust Board in May 2009. Results used to influence internal patient surveys ▪ Increase in number of patient complaints in April 2009, partly attributed to high volume of temporary staff during preceding 3 months
<p>4. Ensure that the quality of care on general wards is not of a poor standard, and take urgent action to improve the quality of nursing in general wards should this be necessary. This includes: -</p> <ul style="list-style-type: none"> ➤ Drs and nurses reviewing patients on a regular basis and monitoring their condition ➤ Identifying and managing any complications that may arise ➤ Ensuring timely review and decision making by senior Drs ➤ Ensuring sufficient equipment is available for the resuscitation of patients, non-invasive ventilation, cardiac monitoring and anticoagulation 	<p>Camilla Wiley Jennifer Worrall Ian Bacarese-Hamilton</p>	<p>Compliant</p> <ul style="list-style-type: none"> ▪ Established structure of ward rounds and multidisciplinary meetings ▪ Access to critical care outreach team for advice ▪ Role of ward manager and nurses in charge of shift ▪ Role and visibility of matrons ▪ Access to clinical site practitioners for advice at all times ▪ Business planning process allows key equipment to be prioritised ▪ Role of senior resuscitation officer ▪ Introduction of global trigger tool, as part of Patient Safety First campaign ▪ Monitoring of incident report forms through Patient Safety Committee ▪ Visible leadership audits/ward rounds ▪ Medical Devices Committee in place and ensures ward equipment is in working order and recommends decommissioning and purchase of new equipment as necessary. This becomes a priority of the Business Planning Group ▪ Incident reporting has category for lack of equipment – there were 15 such incidents reported from clinical areas during 2008-09

<p>5. Ensure there are sufficient medical and nursing staff recruited and available to ensure that patient care is safe and of an acceptable standard, including during the night and at weekends</p>	<p>Morna Carroll Camilla Wiley</p>	<ul style="list-style-type: none"> ▪ Review of duty medical registrars rotas currently underway with the intention of dropping from 3 per day to 2 per day, thus freeing more registrars to cover the medical wards. ▪ Plan in place to have doctors covering emergency department working in blocks so their time away from normal ward work can be better planned ▪ Nursing vacancy rate at April 2009 was 18%. Targeted plans in place for recruitment to reduce to below 10% by March 2010. ▪ Initiatives now set up including recruitment open days for midwifery, ED and theatres. ▪ Nursing recruitment day on 8 June attracted 90 people, of whom 30 were offered posts. Expected to have all started by September 2009 ▪ Criteria for use of temporary staff in place, to increase percentage of shifts filled by bank staff and reduce agency usage
<p>6. Ensure that junior Drs and nurses are undertaking only appropriate duties, are confident and clear about their role and receive appropriate support and supervision</p>	<p>Camilla Wiley Jennifer Worrall Ian Bacarese-Hamilton</p>	<ul style="list-style-type: none"> ▪ Clinical supervision for nurses and statutory supervision of midwives in place ▪ Preceptorship for newly qualified nurses ▪ Mentorship for students ▪ Role of director of medical education ▪ Junior doctors must discuss all ED discharges with a more senior doctor before the patient leaves ▪ Junior Drs on wards/clinics are supervised by consultants in the following ways: <ul style="list-style-type: none"> ➤ Regular consultant wards rounds including all post-take rounds ➤ Direct supervision in operating lists ➤ A mixture of direct supervision and immediate availability for support in outpatient clinics ➤ Assurance from London Deanery Inspections and junior doctor surveys, where we have always received good feedback and the level of supervision provided

<p>7. Ensure there are sufficient theatre sessions to handle emergency demand without delay, and that there is an effective means of determining which emergency cases should receive priority</p>	<p>Matthew Boazman</p>	<ul style="list-style-type: none"> ▪ Compliant with sufficient theatre sessions for emergency demand as have protected trauma and urgent lists. ▪ No robust system in place for prioritising emergency cases at present. Protocol currently being developed and should be implemented in one month, after which will be compliant
<p>8. Ensure there is adequate access to advice and support for clinical staff from senior medical staff in the critical and intensive care service, independent to the availability of beds in the units</p>	<p>Chris Hargreaves</p>	<p>Compliant: Was reviewed as part of successful NHSLA Level 2 assessment</p> <ul style="list-style-type: none"> ▪ "What to do when ITU is full" policy in place ▪ Critical care Outreach Team in place and operate track and trigger system ▪ ITU Consultant on call aware of sick patients outside and within critical care
<p>9. Ensure ED is reviewed to ensure best practice in the following key areas: -</p> <ul style="list-style-type: none"> ➤ Governance ➤ Triage ➤ Environment ➤ Equipment ➤ Leadership, medical cover and supervision of junior Drs ➤ Staffing, leadership and training of nurses ➤ Use of Clinical Decision Units and focus on 4 hourly wait target 	<p>Rachel Landau Neil Brady</p>	<p>Overall complies with recommendations, although work continuing as follows:</p> <p>Environment</p> <ul style="list-style-type: none"> ▪ Environment cleaning scores for last 6 months range from 75% to 99% compliance. New target of 95% set. ▪ Considerable upgrading of the department being carried out and almost completed, including refurbishing of cubicles, new reception area, paediatric ED area, and new flooring. Once completed will be fully compliant <p>▪</p> <p>Senior Leadership</p> <ul style="list-style-type: none"> ▪ Consultant post currently vacant and on-call cover 1:4 ▪ Middle grade vacancies ▪ Substantive Resuscitation Officer – currently filled by locum and out to advert <p>Once above vacancies filled will be compliant</p> <p>Nursing leadership provided by matron for acute care, paediatric ED nurse consultant, and professional development nurse.</p>

		<p>Clinical Decision Unit (Isis Ward) Unit is staffed from within ED; patients remain the responsibility of the ED doctors. Additional nursing posts agreed for Isis and being recruited to ensure good staffing levels across all areas of ED</p> <p>Triage Undertaken by senior nurses. Manchester Triage System in place</p>
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2. Recommendations from Dr David Colin-Thome's Report

Recommendation	Lead	Whittington Position
<p>1. Providers should put in place methods to capture and make use of patient feedback, including "real time" data to pick up issues early.</p> <p>This should be made available to commissioners</p>	Siobhan Harrington	<ul style="list-style-type: none"> ▪ Monthly patient surveys undertaken in ED, OPD, DTC and currently 5 wards (to be increased), including Net Promoter Score ▪ Electronic touch screen real-time feedback systems being introduced in June 2009 ▪ Patient focus groups established ▪ Patient stories captured ▪ implementation of Datix risk management system will enable complaints to be classified under more meaningful headings to provide reports that can be acted upon ▪ Director of Nursing meeting with lead governor to discuss how to make better use of patient complaints and compliments
<p>2. All health care professionals who have contact with patients and the public must report concerns quickly. Providers should have systems in place for healthcare professionals to report concerns easily and quickly and</p>	Deborah Wheeler	<ul style="list-style-type: none"> ▪ System in place to report any actual or potential risks to the Risk Management Team for investigation, including telephone reporting for speed. During October 2008 to March 2009, 1320 clinical incidents were reported, with just over half reported in the required timescale. This is the highest number of incidents reported within a single six month

<p>should be held to account for the setting up of such systems</p>	<p>Margaret Boltwood</p>	<p>period, demonstrating better reporting, but need to improve speed.</p> <ul style="list-style-type: none"> ▪ Implementation of Datix system will improve speed of reporting of adverse incidents by enabling entry straight onto system ▪ “Staff raising healthcare concerns” policy in place (Whistle Blowing) ▪ “Handling concerns about doctors performance” policy in place
<p>3. All organisations should ensure that they are focussing on the broader picture of improving health outcomes rather than solely on interim process measures, and be held to account for improving outcomes through the commissioning assurance system.</p>	<p>Siobhan Harrington Fiona Elliott</p>	<ul style="list-style-type: none"> ▪ Involved in local health and well being / strategic partnerships focussing on improving health outcomes ▪ National demonstrator site for Co-Creating Health in Diabetes ▪ Took part in Islington DH Health Inequalities audit in May 2009
<p>4. All organisations should ensure that they are not relying on national data alone, but should seek to supplement this with local and more granular data, which can then be triangulated to give a more accurate representation of quality.</p> <p>Data from patients and the public must be part of this data set</p>	<p>David Emmerson</p>	<p>Generally compliant although there are problems of comparability/different definitions used by different benchmark sources</p> <ul style="list-style-type: none"> ▪ Where more than one source measures the same concept, then consistency of performance and/or trend between the sources is checked ▪ Benchmark sources are on an alert system - all alerts are checked at local level for potential sources of error and for further identification of the problem area ▪ Benchmark also used for improvement projects and detailed local data is used to measure achievement <p>N.B. Further development is needed to combine data from a number of sources to present a whole system view of quality. There are NHS wide methodological issues about this approach to ensure that only significant inferences are made from the data</p>
<p>5. All organisations should make use of benchmarking data to make comparisons to others.</p>	<p>David Emmerson</p>	<p>Compliant – A number of sources of benchmark information are used and included in the Trust Board Performance Dashboard where appropriate</p> <ul style="list-style-type: none"> ▪ Dr Fosters

		<ul style="list-style-type: none"> ▪ NHS Institute for Innovation and Improvement ▪ Audit Commission PbR bench-marker tool ▪ NHS comparators ▪ Hospital Episode Statistics (HES) ▪ NHS Information Centre ▪ NHS Choices ▪ London SHA information updates ▪ Kings Fund ▪ Care Quality Commission (annual health check and specific reviews) ▪ Clinical and Health Outcomes Knowledge Base ▪ Specialist organisation websites for specific indicators (NPSA, HPA) ▪ London Health Observatory ▪ Office of National Statistics/ Greater London Authority ▪ Locally gathered information <p>N.B Information on where we sit for these can be obtained from David Emmerson</p>
6.All patient safety and quality of patient care data should be made available in the public domain suitably anonymised, unless very special reasons for this not to occur	Fiona Elliott	<ul style="list-style-type: none"> • Included as part of Trust Performance Dashboard
7. All hospital providers, including FTs, must allow PCTs ready access to review their services	Fiona Elliott	<ul style="list-style-type: none"> • In place. No recent service reviews from PCTs
8. All clinicians must speak up for patients when they witness poor quality care. It is their overarching duty.	Celia Ingham-Clark Deborah Wheeler	<ul style="list-style-type: none"> ▪ Visible Leadership Team (VLT) ensures that senior nurses are out in clinical areas on a weekly basis, which makes reporting concerns to them easier ▪ Issues requiring improvement identified by VLT and action put in place, e.g. peripheral cannula training, RCA training for matrons, hand hygiene training for all staff

		<ul style="list-style-type: none">▪ Matrons in post in all areas and encourage their staff to tell them about any concerns▪ Any problems with agency nurses or midwives reported back to agency and staff member stopped from working▪ Staff use the incident reporting system to raise concerns about quality of care
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Mid Staffordshire NHS Foundation Trust:

**A review of lessons learnt for
commissioners and performance managers
following the Healthcare Commission
investigation**

Dr David Colin Thomé

29 April 2009

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Introduction

"This is a story of appalling standards of care and chaotic systems for looking after patients" Sir Ian Kennedy, Chair, Healthcare Commission.

I can only agree. To have poor care throughout the entire emergency care service as occurred at Stafford hospital within the Mid Staffordshire Trust is wholly unacceptable and uncommon. For it to be undetected by any other NHS organisation is disturbing. To have no individual clinicians systematically raising concerns is also uncommon and to me hugely disappointing.

Like my colleague Professor Sir George Alberti, I bring to this review over forty years of being a doctor with a deeply held conviction that clinical leaders supported by good NHS management and systems need to ensure that standards are maintained and such poor care never occurs again. The events of Mid Staffordshire Trust have disturbed us all. All NHS services are important but there can be no better way to judge a health system than how we respond when a patient's need is urgent. It is at that time that all of us feel the most vulnerable and powerless and where the NHS in Stafford particularly failed its patients. What has particularly shocked and disappointed me is that no NHS organisations, staff or representatives of the public reported any serious concerns about emergency services in the hospital. Yet patient complaints and patient surveys all pointed to poor care.

I am proud and passionate to be part of the NHS. It is one of the most just and fair health systems in the world, so when it fails, we need to learn lessons and to do so with determination to make rapid improvements. My report, alongside the report by Professor Sir George Alberti which specifically considers the emergency care issues at Mid Staffordshire NHS Foundation Trust, addresses the wider circumstances of this failure and makes recommendations to ensure that there is no reoccurrence of such failures locally or in the rest of the NHS.

Following the Healthcare Commission's independent report and other respective reviews, there are some key lessons specifically for Mid Staffordshire NHS Foundation Trust. My report seeks to look beyond the hospital and make recommendations directed towards the other relevant organisations that also act to safeguard the quality of care for our patients and populations.

The main responsibility for the failures that have occurred in this case rests with the management board and the staff, including the clinicians, of Mid Staffordshire NHS Foundation Trust. However other organisations, including the PCT as the local leader of the NHS and the commissioner of services, and the local SHA with responsibility for oversight and management of the health system, also have lessons to learn and improvements to take forward. A key lesson is that all organisations should be focused on prioritising high quality patient care as judged by outcomes, and whilst process targets are very helpful on the journey, they must not become a distraction from the bigger picture.

My report balances an analysis of what has happened with a look forward to what we can do to prevent the same issues happening again locally but also to provide advice to the rest of the NHS to ensure such failure of care does not happen elsewhere. Passion, conviction and fine words are of little value if the implementation of recommendations by the NHS does not take place.

My report has no quasi-judicial status and throughout my visits and discussions, I sought to ask non-judgemental questions with no intention of apportioning individual blame. In response, I found individuals willing and open to discussing issues with honesty, and for that I am very grateful. I wish to acknowledge the many people who gave their time to help me in my review including many of those who are seeking to learn lessons and implement recommendations to ensure that care for the people of South Staffordshire is improved in the light of the issues that have arisen.

A handwritten signature in black ink, appearing to read 'David Colin-Thomé'.

David Colin-Thomé
National Director for Primary Care

Executive summary

This review focuses on the South Staffordshire healthcare system in the period preceding the independent Healthcare Commission investigation, between 2002 and 2007. It provides an analysis of the issues that have now come to light, and makes recommendations to ensure that these issues do not occur in future either locally or nationally.

Within the local reporting systems employed by the NHS between 2002 and 2007, no concerns about the hospital trust came to light. On balance, there is nothing within the Healthcare Commission Report to suggest that the Primary Care Trust (PCT), West Midlands Strategic Health Authority (SHA) and their predecessors contributed to the problems at Mid Staffordshire NHS Foundation Trust or missed signs in the nationally recognised approaches to managing performance which operated in the NHS at that time. My review has confirmed that while the national approaches were being followed, local signs were missed.

On reflection, and with the benefit of hindsight, there are lessons to be learned from that time. A central theme of the failures at Mid Staffordshire hospital trust appears to be an over reliance on process measures, targets and striving for Foundation Trust status at the expense of an overarching focus on providing quality services for patients. Targets and process measures have their place, but they must be considered as a set of tools for improving the quality of care provided.

Use of data and local information

Both the SHA and PCT state that they first detected problems in patient care from the 2007 Hospital Standardised Mortality Rate (HSMR) data. HSMR data has featured prominently in the Mid Staffordshire investigation and prompted much ill informed speculation and comment as to suppose excess deaths at the hospital.

HSMR data is not a measure accurate enough to be used as an absolute indicator of quality and safety, but like all indicators, it is one measure, and can indicate a problem. No one data source is sufficient to provide the full picture of an organisation, and triangulation of data is key. National data sources are relevant and helpful, but there must not be over reliance on these sources, as local intelligence should supplement these to provide a broader range of information.

The culture and narrow focus of the performance management system at that time may have been a limiting factor. Broadening the approach to performance management to ensure that views from patients, relatives and staff take equal place with the existing data on delivery of national and local priorities will ensure that performance improves and organisational and system health can be assured.

Although the main responsibility for such poor patient care clearly rests with the hospital staff and its board of management, including the professional responsibility of clinicians for the care of individuals, the PCTs and SHAs also had a role to play.

The Mid Staffordshire hospital trust demonstrated a closed culture with a lack of sharing of data and information that allowed poor care to continue undetected. However, locally the PCTs and SHAs did not seek out data to ensure quality of outcomes, either in their roles as commissioner, performance manager or with responsibility for oversight of the local health system. It is of concern for instance that reporting to the hospital trust board on patient complaints was suspended in 2003 until 2006, but the PCTs of the time were not aware of this and therefore did not provide a challenge. The culture of providing poor quality care was therefore allowed to continue for a period of time unrecognised. This was not acceptable and my report makes recommendations to take forward improvements.

Since 2006, and even more so since the start of the Healthcare Commission investigation, the current PCT has taken a necessary hands-on role working with the hospital trust. I do not want to recommend that today's NHS commissioners micro manage every detail of how providers deliver care, but I will set out the need for a greater awareness and responsibility for safeguarding quality of services. This is particularly relevant where the provider has a closed culture of data sharing.

Governance and accountability

A number of organisations have been the subject of investigation and review in the Mid Staffordshire case, including the hospital trust, the PCTs, SHAs and regulators. There are lessons to be learnt by all of these organisations, but there are also lessons for the wider system.

A key lesson has been about the need for clarity of role and responsibility to ensure that each organisation understands where it fits and what accountability it has. This was not clear in Mid Staffordshire and there were cases of issues falling between organisations.

Another key factor in the failure to act on poor quality of care was lack of continuity and handover between organisations when reconfigurations and staff changes took place. But hindsight suggests that despite the time involved in establishing the new organisations and the loss of corporate memory, the reconfigurations and merging of the three SHAs and the four PCTs in South Staffordshire has been effective in pooling expertise in the area and strengthening the management of the health system.

The role of the PCT as commissioner, performance manager and guardian of high quality care for their local populations remains unchanged when hospitals become Foundation Trusts. There are for instance several reports of Foundation Trusts making themselves somewhat inaccessible to their commissioners. This is unacceptable, as Foundation Trusts are part of the NHS and must always act accordingly as true partners in an accountable service.

Patient and public involvement

Patient feedback is essential for a responsive service. There are many ways that acute trusts, PCTs and SHAs can listen to and act on feedback from their local patients and populations. Hard data sources include surveys, complaints processes reports and recommendations from Local Involvement Networks (LINKs), the Healthcare Commission/Care Quality Commission annual health check, and incident review, but trusts also need to be able to look at 'soft' intelligence to see if there are concerns that are being missed or are taking too long to be identified. In the case of Mid Staffordshire hospital, the trust, PCTs past and present and SHAs past and present do not appear to have taken notice of signs that were present in the survey data and in complaints that indicated poor patient care.

I feel very strongly that a lack of good patient engagement is the key to why Mid Staffordshire hospital trust continued to provide poor care for a protracted period of time. Every part of the health system, not only A&E services could have done more to hear patients' concerns and to make changes in the system – clinicians, managers at the hospital trust, PCT, SHA and regulators – all need to take responsibility for this.

Patient empowerment is a theme throughout my review, and I hope my recommendations in relation to patient empowerment are taken to heart by the NHS. It appears to me that the services were designed around clinical and organisational needs rather than patients. This needs to change. Patients must be more involved in the design, delivery and quality assurance of their services.

Real patient and public power, information and choice are strong drivers for improving the NHS and making it a dynamic, responsive service rather than a service that gives patients the message that they should accept what they are given.

Clinical leadership

Effective, accountable clinical leadership at all levels of the NHS from where patients are treated and cared for right up to the board of an organisation, is another essential pre-requisite of a safe, high quality and effective service. In Mid Staffordshire hospital trust, this was lacking. It could also have been more effective in the PCTs and SHAs.

We need to make more use of General Practitioners' as well as incidentally MPs' and councillors' feedback in future as they are the 'eyes and ears' of their communities. As a clinician myself, I feel very passionately that all clinicians must play a crucial role in protecting patients' interests and leading on quality in the NHS, both in direct care of patients and at every management level through to senior board level roles.

My recommendations are directed locally but also to the whole of the NHS across England, as lessons learned from South Staffordshire should prevent failure to care and improve the health and care provided for patients and populations everywhere.

The recommendations cover four areas:

1. Involving patients and the public
2. Commissioning for outcomes supported by excellent use of appropriate data and information
3. Ensuring governance and clarity of accountability of all the different organisations in the system
4. Clinical leadership

Current health policy provides a solid platform for taking forward these recommendations. World class commissioning seeks to strengthen the role of PCTs as commissioners, holding them to account for commissioning for outcomes and taking responsibility for the health and care of their populations in a more rigorous and systematic manner. Professor Lord Darzi's report High Quality Care for All, focuses the health service on quality, placing it at the centre of patient care. The context is set, and my recommendations seek to accelerate improvements in South Staffordshire and across the whole of the NHS.

Terms of reference

In response to the Healthcare Commission's findings, the Secretary of State for Health asked me to:

"...review the circumstances surrounding the Mid Staffordshire NHS Foundation Trust prior to the Healthcare Commission's investigation to learn lessons about how the primary care trusts and the strategic health authority, within the commissioning and performance management systems that they operate, failed to expose what was happening in this hospital".

My review seeks:

- To review the reasons why South Staffordshire PCT and West Midlands SHA did not become aware of and take action in relation to failings at Mid-Staffordshire NHS Foundation Trust in the time before the Healthcare Commission's investigation (covering the period 2002 – 2007).
- To link closely with and complement the review being undertaken by Professor Sir George Alberti on emergency care procedures at the trust.
- To make recommendations on what commissioners, including both GPs and PCTs, and performance managers across England can learn from the case to be sure they are advocating effectively on patients' behalf.
- To set out what steps commissioners should reasonably be expected to take in assessing the risks of services they purchase on behalf of their communities.

Analysis of events 2002-2007

This section seeks to provide an additional analysis of the issues in South Staffordshire to that undertaken independently by the Healthcare Commission, and focuses on the period between 2002 and 2007. I have gathered the evidence for this analysis from a series of visits and discussions with managers, clinicians and patients in South Staffordshire at the hospital trust, PCT, SHA, and from a review of key documents. Much of my analysis has been gathered verbally due to a lack of formally documented paperwork, a theme I will develop further in the report. My analysis does not seek to duplicate the independent Healthcare Commission investigation.

Summary timeline

This timeline sets the context for the narrative in this chapter. A more detailed timeline is at Annex A.

January 2002	Commission for Health Improvement (CHI) publishes clinical governance report on Mid Staffordshire hospital trust
July 2002	Hospital trust awarded 2 star rating by CHI
July 2003	Hospital trust awarded 3 star rating by CHI
July 2004	Hospital trust awarded 0 star rating by the Healthcare Commission
July 2005	Hospital trust awarded a 1 star rating by Healthcare Commission
July 2006	West Midlands SHA is formed
October 2006	South Staffordshire PCT is formed
October 2006	Mid Staffordshire hospital trust assessed as Fair-Fair in 2005/06 Healthcare Commission Annual Health Check
April 2007	Dr Foster's Good Hospital Guide classifies Mid Staffordshire hospital trust as having high mortality rates.
Summer 2007	Healthcare Commission reviewed core standards at Mid Staffordshire hospital trust
October 2007	Mid Staffordshire hospital trust assessed as Good-Fair in 2006/07 Healthcare Commission Annual Health Check
February 2008	Mid Staffordshire formally awarded Foundation Trust status by Monitor
March 2008	Healthcare Commission launches a formal investigation into mortality rates at Mid Staffordshire NHS Foundation Trust.
October 2008	Healthcare Commission investigation phase completed

October 2008	Healthcare Commission provisionally rate the Trust Good-Good in their 2007/2008 Annual Health Check. The quality rating was later re graded to “weak”.
November 2008	Dr Foster’s 2008 Hospital Guide classifies Trust as having significantly higher than expected mortality rates.
March 2009	Chair and Chief Executive stand down. Interim Chair and Chief Executive take up posts.
17 March 2009	Healthcare Commission publish the report of their investigation

Commission for Health Improvement Clinical Governance Review (2002)

A Clinical Governance review by the Commission for Health Improvement (CHI) was undertaken in 2002. This led Mid Staffordshire hospital trust to put in place an action plan to address the issues raised including high numbers of emergency admissions, maintaining patients’ privacy and dignity, disseminating learning from the outcomes of complaints, the numbers of nurses and to develop an open and learning culture.

In 2002/3, CHI awarded the trust a three star rating, noting that the trust had a strong action plan in response to its review. Unfortunately, as I will set out throughout this review, it seems that some of the poor patient care in the hospital trust, particularly in emergency care, and the inadequate staffing, persisted.

Although the main responsibility for such poor patient care clearly rests with the hospital staff and its board of management, including the professional responsibility of clinicians for the care of individuals, there was also a commissioning, performance management and oversight role for the PCTs and SHAs.

PCT and SHA activity (2002 to 2006)

In the period before the reconfigurations of PCTs and SHAs in 2006, the PCT and SHA organisations with responsibility for commissioning and performance managing Mid Staffordshire hospital trust were smaller and had fewer human and financial resources per organisation than they do now. SHA managers from the period prior to 2006 told me that there were financial pressures in the local health system and not enough staff to provide detailed management of all the provider organisations. The SHA and PCT were not aware of any major problems or concerns at the hospital trust, and they considered that the regulator at the time, CHI was responsible for assuring quality of care.

Therefore, when CHI awarded the hospital trust a three star rating in 2002/03, the PCT endorsed more autonomy for the hospital trust. However, following a zero star rating the following year (2003/4), which was mainly due to poor performance on targets relating to access and waiting times, it was not clear that any robust action was taken by the then PCTs and SHAs with the hospital trust to improve their performance.

Alongside the warning of the zero star rating, there were other formal indications of issues at the hospital trust. It performed poorly in emergency department patient surveys of 2003/4 and 2004/05, and again in an inpatient survey in 2007. Medical and nursing staff numbers dropped in 2004, and managerial staff numbers dropped

in 2005 and 2006. Staff surveys did not show serious concerns before 2005, however in 2006 and 2007, there was a marked deterioration.

In 2005, the SHA performed diagnostic processes with all local hospital trusts to assess their readiness for foundation trust status. Some concerns were identified with Mid Staffordshire hospital trust, including poor relationships between managers and clinicians, but these were seen as relatively minor concerns.

It seems that during the period 2002 to 2006, likely in common with many other PCTs and SHAs, the focus of the local PCTs and SHAs was on finance. In the case of South Staffordshire, this was potentially at the expense of quality of care. The PCT with main responsibility for commissioning of care from Mid Staffordshire hospital trust, South West Staffordshire PCT, was in formal financial turnaround at the time. In response, staff cuts at the hospital trust were made to achieve financial savings without adequate assessment of the impact, either intended or unintended, on patient care. As CHI reported, this was in a hospital trust that was already understaffed.

Reporting to the hospital trust board on patient complaints was suspended in 2003 until 2006, but the PCT was not aware of this and therefore did not provide a challenge. The hospital trust itself was perceived as having a 'closed' culture, and were not open with sharing of information. PCT managers I have interviewed felt that whilst the role of the PCT had changed in recent years, at the time their boards felt they were not expected to take an active role in assuring high quality of care within their providers. This seems unacceptable to me and is an area where expectations have now changed considerably and PCTs have greater responsibility for performance management of the quality of care provided.

Reconfiguration of the SHA

West Midlands SHA was formed in July 2006 from Staffordshire and Shropshire, Birmingham and the Black Country and West Midlands South SHAs. For a few months, transitional arrangements were in place prior to the formal setting up of the new SHA. A temporary manager was appointed for each of the three outgoing SHAs areas and no major concerns about the trust were passed on to the transitional team nor did they arise during their short tenure.

Reconfiguration of the PCT

South Staffordshire PCT was formed in October 2006 from four PCTs (Burntwood, Lichfield and Tamworth, Cannock Chase, and East Staffordshire and South Western Staffordshire PCTs). As the Healthcare Commission investigation found, neither the new SHA or PCT were given any indication of poor patient care at the hospital trust during the transition to the new organisations. The only effective handover of information appears to have been on the financial health and human resourcing of the organisations.

Although knowledge transfer in relation to information about the quality of care at the hospital trust was weak, some actions were taken by the new PCT to learn from organisational memory during the transition. All four Chairs were appointed to a transition Board, and all four Professional Executive Committee (PEC) chairs (formally appointed clinical leads advising the PCT) were appointed to a transition PEC. A number of Non Executive Directors also transferred to the new organisations.

During this transition, no concerns about the hospital trust were raised. The Appointments Commission was involved in appointing Non Executive Directors and the SHA was involved in appointing board level Executives. Following the transition period these members were required to formally apply for jobs in the new organisation. Neither of the Chief Executives of South West Staffordshire and Cannock Chase PCTs, which had financial deficits at the time of the merger, were successful in securing posts in the new PCT. There was also a loss of a number of the Non Executives from the same PCTs. The reorganisation and the subsequent appointments process delayed the ability of the PCT to focus on their primary role of commissioning and managing health services for their population.

The newly formed PCT focused on addressing the financial problems of the two failing PCTs prior to the merger, which was achieved in part by selling assets rather than cutting PCT patient services. In relation to the hospital trust, the PCT focused on reconciling a situation where there were three contracts drawn up by the individual outgoing PCTs, resolving disputes, and tackling an issue of delayed clinical letters. The PCT Chief Executive began a programme of visits to GP practices in the area. The transition board, PEC board, nor GPs raised any issues about patient care in the hospital trust. It appears that the first indications to both the PCT and the SHA of any problems at the trust were in the 2007 Hospital Standard Mortality Rate (HMSR) data.

Improvements have been made

Since 2006, and even more so since the start of the Healthcare Commission investigation, the PCT has taken a hands-on role working with the hospital trust. This has included placing a GP service in A&E which has been effective in reducing numbers of patients with minor complaints waiting in A&E. However, there is still more scope to develop this service, and to more firmly focus on outcomes alongside process, as I will set out in my recommendations. The PCT have advised me that some patients with non major clinical conditions remained in the main A&E after triage staff judged that their condition did not meet the GP protocol. 126 patients breached the 4 hour standard in that period.

Other improvements have been made, including the start of regular clinical reviews with the PCT who have taken a strong lead in managing change at the hospital trust, which is appropriate in the short term given the serious concerns raised by the Healthcare Commission report. Hindsight suggests that despite the time involved in establishing the new organisations and the loss of corporate memory, the reconfigurations and merging of the three SHAs and the four PCTs in South Staffordshire has been effective in pooling expertise in the area and strengthening the management of the health system.

There have been improvements since 2006 in effective engagement with the hospital trust, although there is a great deal still to do and especially in all aspects of emergency care. The PCT has commissioned more services which has given the hospital trust considerably more resources to fund more staff but improvements now need to focus on the quality of care and in particular basic and general nursing care on the wards.

Conclusion

My review is not to apportion blame as NHS staff do not come to work to do harm. Nevertheless, there is a danger that they can work in a culture where poor quality care is not challenged and this must not occur.

Within the local reporting systems employed by the NHS between 2002 and 2007, no concerns about the hospital trust came to light. With hindsight and in undertaking this review, evidence of poor care has emerged that was not collated or challenged by the PCTs or SHAs at the time. In addition, the lay Public and Patient Involvement (PPI) forum was largely uncritical of the hospital. It is of concern that issues of poor care were able to go undetected.

I do not want to recommend that today's commissioners micro manage every detail of how providers deliver care, but I will set out the need for a greater awareness and responsibility for safeguarding quality of services. This is particularly relevant where the provider has a closed culture of data sharing.

PCTs are the local leaders, funders and the commissioners of the NHS and in that role have overall responsibility for ensuring that health and care services are patient and population centred. World class commissioning makes this clear and since 2008, holds PCTs firmly to account for this responsibility through the Commissioning Assurance System.

The SHA role, has also recently been strengthened with an overall system management responsibility including all the providers (but not directly Foundation Trusts), and commissioners in their area.

Analysis of past events is vital to understanding why failures happened, and the review that I have undertaken has uncovered evidence that went undetected at the time. However, the focus must be on the future taking key lessons and making improvements. There is high public profile surrounding the issues at Mid Staffordshire NHS Foundation Trust, which has been entirely appropriate. My review seeks to acknowledge that more could and should have been done, and to make recommendations to take forward change.

Summary of recommendations

Involving patients and the public

1. Providers should put in place methods to capture and make use of patient feedback, including 'real time' data to pick up issues early. They should make this data available to their commissioners.
2. Through world class commissioning, particularly competency three of the Commissioning Assurance System, PCTs should be held to account for their responsibility for engaging patients and the public in design, delivery and quality assurance of health and care services, and for ensuring that the providers that they commission do likewise.
3. All health professionals who have contact with patients and the public must report concerns quickly. PCTs and providers should have systems in place for healthcare professionals to report concerns easily and quickly and should be held to account for the setting up of such systems.
4. Patients and the public should be provided with, and made more aware of, methods to support their engagement, particularly where they have concerns.
5. Monitor should consider how to support a strengthened role for governors of Foundation Trusts to work more closely with their PCT.
6. The Department of Health should review whether the new complaints procedure has improved the complaints process with particular consideration of its independence to act if local systems are not sufficient.

Commissioning for outcomes supported by excellent use of appropriate data and information

1. All organisations, and particularly PCTs as local leaders of the NHS and as commissioners should ensure that they are focusing on the broader picture of improving health outcomes rather than solely on interim process measures and be held to account for improving outcomes through the Commissioning Assurance System within world class commissioning.
2. All organisations, and particularly PCTs should ensure that they are not relying on national data alone, but should seek to supplement this with local and more granular data which can then be triangulated to give a more accurate representation of quality. Data from patients and the public must be a part of this data set.
3. Any evidence however early, 'soft' and informal that reveals consistent patient and public concern, must be investigated by the PCT.
4. PCTs should ensure that they increase their capability and capacity to review, interpret and use data, and they should be held to account for these competencies.
5. All organisations, and particularly PCTs should make use of benchmarking data to make comparisons to others. Regional Quality Observatories can effectively support these comparisons.
6. All patient safety and quality of patient care data collected by providers for presentation to their board should be made available in the public domain suitably anonymised, unless there are very special reasons for this not to occur. The PCT working with the SHA, or for Foundation Trusts, their regulator Monitor, should be privy to the reasons why anonymised performance information is not in the public domain. This will ensure that provider services are more transparent and accountable to patients and the public and that all organisations, and particularly commissioners, can triangulate as many sources of information as possible and will enable them to act intelligently where one data source, however flawed, might indicate a concern to be investigated.

Ensuring governance and clarity of accountability of all the different organisations in the system

1. PCTs as local leaders of the NHS must assume ultimate responsibility for commissioning safe services and improving the health of their patients and populations.
2. All hospital providers including foundation trusts must allow PCTs ready access to review their services.
3. SHAs are the regional headquarters of the NHS, and in that role must ensure that the whole healthcare system discharges its responsibilities, with a particular emphasis on the performance management of PCTs to ensure that they are taking forward their leadership role. The Commissioning Assurance System for world class commissioning provides a framework for taking this forward.
4. PCTs and SHAs must be more proactive in informing Monitor of any concerns prior to foundation trust application and not assume that the regulators will take responsibility for ensuring quality of care. The regulators must share data and early concerns to allow PCTs and SHAs to take action.
5. The Department of Health should describe how the roles of PCTs, SHAs and the regulators are different and how they interrelate.
6. The Department of Health should set out clear expectations on all health organisations that effective 'business continuity planning' is the norm, and work in co-production with the NHS to develop guidance for organisational transition, including effective formal record keeping.
7. The NHS Confederation should consider how it can support PCTs through its network to develop their capacity and capability to respond to their role as local leaders of the NHS following lessons to be learnt from this review.

Clinical leadership

1. PCTs should review their clinical leadership arrangements at board level to ensure that they are effective. Separate responsibility for medical and nursing director input at board level should exist with a remit to ensure clinical quality across the whole healthcare system on behalf of the PCT.
2. PCTs should review the effectiveness of their Professional Executive Committee (PEC) as advisors to the PCT board, and in particular the role of the PEC in quality assurance.
3. PCTs should further support the development of practice based commissioning and should be held to account for doing so through the Commissioning Assurance System within world class commissioning.
4. PCTs should take greater responsibility for awareness of provider staff issues e.g. staffing levels and quality of care, through their risk management and performance management roles in commissioning.
5. All clinicians must speak up for patients when they witness poor quality care. It is our overarching duty.

Involving the public and patients

There were failures in Staffordshire, at the hospital and the PCT, to hear messages from patients about poor quality of care. This was in part a failure of the local health system but my recommendations also challenge the current policy and processes to go further faster.

Evidence

Prior to April 2008, a Patient and Public Involvement (PPI) forum was in place which appears to have fed in generally positive messages to the hospital trust, in contrast to the experiences described by members of the group 'Cure the NHS' who have expressed concerns going back to the same period that the PPI was active. In April 2008 following new legislation, the PPI was abolished, and was replaced by Local Involvement Networks (LINKs) which have a wider remit, covering social care as well as health. LINKs have great potential for being the independent local body that the public requires but are still formative in their infrastructure in South Staffordshire.

I did speak to the trust's Patient Advice and Liaison Service (PALS). They reported better systems for complaints within the hospital were in now place, which were linked with the PCT and included analysis of trends using National Patient Safety Agency (NPSA) categories and formal review panels. The PCT has stated that regular reporting of complaints to them has been in place since April 2008, and that they are actively reviewing their policy on handling complaints.

The PCT had opportunities to pick up patient feedback through national patient surveys and could have offered more challenge to the trust in relation to its complaints processes. Since the start of the Healthcare Commission investigation, the PCT has made improvements in its patient and public engagement. As well as improving its review of complaints since April 2008, it has also put in place systems for GPs to raise issues about patient care in the acute trust, including reporting forms and a helpline, although only a small number of concerns have been raised through this route.

There are many ways that acute trusts, PCTs and SHAs can listen to and act on feedback from their local patients and populations. Hard data sources include surveys, complaints processes reports and recommendations from Local Involvement Networks (LINKs), the Healthcare Commission/Care Quality Commission annual health check, and incident review, but trusts also need to be able to look at 'soft' intelligence to see if there are concerns that are being missed or are taking too long to be identified. In the case of Mid Staffordshire hospital, the trust, PCTs past and present and SHAs past and present do not appear to have taken notice of signs that were present in the survey data and in complaints that indicated poor patient care.

They also failed to take a proactive approach to gathering 'soft' data which could have helped them to hear the concerns of patients far earlier and louder. Some concerns are still being expressed, mainly about care on the wards.

Obtaining 'real time' patient experience information can show that even when an organisation is performing well overall, more detailed feedback about patients' experience can sometimes show that some wards, departments or services are performing less well.

Good practice exists, for example,

Luton and Dunstable NHS hospital foundation trust invites patients with complaints to present to their board.

Tower Hamlets PCT has a service alert process where GP practices submit concerns about individual patient care to the acute trust, and this is monitored by the PCT and practice based commissioning groups.

Conclusion

I feel very strongly that a lack of good patient engagement is the key to why Mid Staffordshire hospital trust continued to provide poor care for a protracted period of time. Every part of the health system, not only A&E services could have done more to hear patients' concerns and to make changes in the system – clinicians, managers at the hospital trust, PCT, SHA and regulators - all need to take responsibility for this. Patient empowerment is a theme throughout my review, and I hope my recommendations in relation to patient empowerment are taken to heart by the NHS. It appears to me that the services were designed around clinical and organisational needs rather than patients. This needs to change. Patients must be more involved in the design, delivery and quality assurance of their services.

Real patient and public power, information and choice are strong drivers for improving the NHS and making it a dynamic, responsive service rather than a service that gives patients the message that they should accept what they are given. Patients should be seen as equal partners in their own care described as 'the meeting of two experts' when a patient meets their clinician.

There is a role for the use of hard data and soft intelligence, and for all parts of the health system to embed patient and public engagement in the design and delivery of services.

Recommendations

- 1. Providers should put in place methods to capture and make use of patient feedback, including 'real time' data to pick up issues early. They should make this data available to their commissioners.**
- 2. Through world class commissioning, particularly competency three of the Commissioning Assurance System, PCTs should be held to account for their responsibility for engaging patients and the public in design, delivery and quality assurance of health and care services, and for ensuring that the providers that they commission do likewise.**
- 3. All health professionals who have contact with patients and the public must report concerns quickly. PCTs and providers should have systems in place for healthcare professionals to report concerns easily and quickly and should be held to account for the setting up of such systems.**
- 4. Patients and the public should be provided with, and made more aware of, methods to support their engagement, particularly where they have concerns.**
- 5. Monitor should consider how to support a strengthened role for governors of Foundation Trusts to work more closely with their PCT.**
- 6. The Department of Health should review whether the new complaints procedure has improved the complaints process with particular consideration of its independence to act if local systems are not sufficient.**

Commissioning for outcomes supported by excellent use of appropriate data and information

There were failures by the hospital trust, PCTs and SHAs to focus on quality of patient care with claims of distractions such as finance, achievement of foundation trust status and reconfigurations. World class commissioning and *High Quality Care for All* promote a renewed emphasis on commissioning for outcomes and delivery of quality services and offer an appropriate platform for improvement.

Commissioning for outcomes, rather than a sole reliance on process and national targets, requires improved use of data and information. And delivery of quality also seeks out improved use of data to judge that quality.

Evidence

A central theme of the failures at Mid Staffordshire hospital trust appears to be an over reliance on process measures, targets and striving for foundation trust status at the expense of an overarching focus on providing quality services for patients. Targets and process measures have their place, but they must be considered as one of a set of tools.

Prior to 2006, the quality agenda of the hospital was addressed at board level in the PCTs only to a limited degree as data on access and waiting times were given higher importance. Although both of these are important, they are not the only measures of quality. The SHA and PCT state that they first detected problems in patient care from the 2007 Hospital Standardised Mortality Rate (HSMR) data.

When concerns about high HSMRs at Mid-Staffordshire (and other Trusts) were raised, the SHA responded by meeting with all of the Trusts with high HSMRs and reviewing their approaches to clinical audit. The SHA then asked Birmingham University to look at the extent to which the hospitals identified as having high HSMRs provided poor quality of care. This review did not identify significant problems with the quality of care at Mid-Staffordshire.

HSMR data has featured prominently in the Mid Staffordshire investigation and prompted much ill informed speculation and comment as to suppose excess deaths at the hospital. HSMR data is not accurate enough of a measure to be used as an absolute indicator of quality and safety, but like all indicators it is one measure and can indicate a problem. I would argue that in Mid Staffordshire, there was evidence available to indicate a problem prior to this data. However the right data, and from insufficient sources was not collated and reviewed. There was a reliance on the data that Mid Staffordshire hospital trust reported nationally and insufficient scrutiny given to local sources. To measure quality well, we need to have access to a range of indicators, however action should be taken to investigate when any data source indicates that there might be a concern.

The focus of the PCT was not on commissioning for outcomes, but rather a reliance on pre-determined process. For example, the financial pressures in 2006 clouded the judgements of the PCT and the hospital trust. Staffing cuts were made with insufficient consideration of the impact on quality and safety of care. Finance was the overriding driving factor in the decision making process without seemingly an appreciation that better quality of care is also often the most cost effective care.

In addition, there was not the expertise, particularly in the PCT to interpret data that was available. Where concerns might have been noted in data, a judgement was taken that the coding was poor and therefore the value of the data was seen as limited.

Many improvements have now been made. World class commissioning focuses on commissioning for outcomes and places process measures only as one of a number of inputs. The Commissioning Assurance System holds PCTs to account for commissioning for outcomes. South Staffordshire PCT have been through the first year of this system and received an average rating, as compared to other PCTs nationally, in their commissioning competencies.

The PCT has worked with the hospital trust to develop a set of quality indicators and the PCT board and the PEC receive a regular report of quality measures from the hospital trust. The PCT has also employed a full time analyst to sample and review data, strengthening the expertise within the organisation.

Conclusion

There are a number of conclusions to be drawn around commissioning and data. The first is that commissioning must concentrate on the bigger picture and the end goal of securing quality and safe services for patients. Commissioners and providers must not become distracted by interim process measures and targets, despite the usefulness of these tools as checks and markers along the way. Quality must sit at the heart of services, both in commissioning and in delivery.

And quality and safety must be measured. No one data source is sufficient to provide the answer, and triangulation is key. National data sources are relevant and helpful, but there must not be over reliance on these sources as local intelligence should supplement these to provide a broader range of information.

Expertise in data analysis is a vital skill for all organisations, and PCTs should seek to increase their capability in this area to ensure that they are able to make best use of, and best judgements, using the growing number of information sources available. Data should be reviewed, sampled, and concerns arising should be investigated. Benchmarking and comparison across populations and with other data sources will increase the value of the story that the data can convey. As set out in my earlier section on patient and public involvement, the value of patient views and patient data should not be underestimated, and should be incorporated as central elements of these datasets.

Good practice exists, for example:

Oldham PCT's Advancing Quality Programme measures three quality indicators – clinical outcomes, patient reported outcomes and patient experience. It triangulates these sources and offers financial incentives for the top hospitals achieving against these indicators.

NW SHA are taking a whole system approach to developing more locally owned and delivery standards focusing on quality. These will be defined by front line staff, drawing on the NW's Advancing Quality programme, and will be reviewed every six months and progress against them publicly reported.

Recommendations

1. All organisations, and particularly PCTs as local leaders of the NHS and as commissioners should ensure that they are focusing on the broader picture of improving health outcomes rather than solely on interim process measures and be held to account for improving outcomes through the Commissioning Assurance System within world class commissioning.
2. All organisations, and particularly PCTs should ensure that they are not relying on national data alone, but should seek to supplement this with local and more granular data which can then be triangulated to give a more accurate representation of quality. Data from patients and the public must be a part of this data set.
3. Any evidence however early, 'soft' and informal that reveals consistent patient and public concern, must be investigated by the PCT.
4. PCTs should ensure that they increase their capability and capacity to review, interpret and use data, and they should be held to account for these competencies.
5. All organisations, and particularly PCTs should make use of benchmarking data to make comparisons to others. Regional Quality Observatories can effectively support these comparisons.
6. All patient safety and quality of patient care data collected by providers for presentation to their board should be made available in the public domain suitably anonymised, unless there are very special reasons for this not to occur. The PCT working with the SHA, or for Foundation Trusts, their regulator Monitor, should be privy to the reasons why anonymised performance information is not in the public domain. This will ensure that provider services are more transparent and accountable to patients and the public and that all organisations, and particularly commissioners, can triangulate as many sources of information as possible and will enable them to act intelligently where one data source, however flawed, might indicate a concern to be investigated.

Ensuring governance and clarity of accountability of all the different organisations in the system

A number of organisations have been the subject of investigation and review in the Mid Staffordshire case, including the hospital trust, the PCTs, SHAs and regulators. There are lessons to be learnt by all, but there are also lessons for the wider system. A key lesson has been about clarity of role and responsibility so as to ensure that each organisation understands where it fits and what accountability it has. This was not clear in Mid Staffordshire and there were cases of issues falling between organisations. There were also issues of poor handover when organisations were reconfigured and a lack of formal documentation of decisions has compounded the problem. This likely contributed to the ongoing failures in patient care.

Evidence

There was over reliance by the PCTs and the SHAs on Monitor and the Healthcare Commission to ensure quality of care at Mid Staffordshire hospital trust. As discussed in the previous section on data, triangulation of data sources gives the most accurate picture, the PCTs and SHAs relied on too few sources. They assumed that regulation of quality would be fulfilled by the Healthcare Commission and Monitor and took on a lesser role than was appropriate or required of them. The regulators should also have taken a stronger role in sharing their concerns more explicitly with the PCT when they came to light. The new Care Quality Commission is now considering putting in place 'risk summits' which would bring together the provider, PCT and SHA and Monitor together to openly discuss concerns and risks should they emerge.

There was also lack of clarity over the respective roles of the SHA, PCT and Monitor once Mid Staffordshire hospital trust achieved foundation trust status. The SHA and PCT, in particular, were unsure of their ongoing management relationship with the Foundation Trust, in relation to the independent regulation role taken on by Monitor. Monitor have received criticism for approving Mid Staffordshire's foundation trust status when the trust was to be investigated by the Healthcare Commission, and have since reviewed their process for approval. Monitor in turn emphasise that prior to the foundation trust application process, both the SHA and PCT had an opportunity to comment on a hospital's suitability.

The role of the PCT as commissioner, performance manager and guardian of high quality care for their local populations remains unchanged when hospitals become foundation trusts. There are for instance several reports of foundation trusts making themselves somewhat inaccessible to their commissioners. This is unacceptable, as foundation trusts are part of the NHS and must always act accordingly as true partners in an accountable service.

Promoting world class commissioning, the accountability of the PCT as local leader of the NHS has been further strengthened. Where commissioners have concerns or are not assured about the quality of care, they have the responsibility to intervene. There are a number of levers they can use, starting with dialogue with the providers, through use of contracts, and escalating to notification of the regulators.

The role of the SHA does change once a hospital trust receives foundation status. Their responsibility changes from oversight of both the PCT and the hospital trust, to responsibility for ensuring that the PCT is discharging its duty in relation to the foundation trust. The SHA must ensure that the PCT is undertaking its commissioning and performance management roles in relation to its providers and it uses the Commissioning Assurance System to hold PCTs to account.

The other key influence in the failure to act on poor quality of care was lack of continuity and handover between organisations when reconfigurations and staff changes took place. In the reconfigurations of both the PCTs and the SHAs in 2006, both the old and new organisations took insufficient steps to transfer knowledge either verbally, or more significantly through formal documentation. The latter has become particularly obvious in undertaking this review as few formal documents have been readily available. In the case of the SHA, it appears that the only information that was adequately handed over were the financial records, as required by law. West Midlands SHA management team have acknowledged these inadequacies and that a 'legacy' document detailing quality and risk, past and present investigations, performance and financial positions should have been made available.

Since January 2003, every local authority with social services responsibilities have had the power to scrutinise local health services. Local Authority Overview and Scrutiny Committees (OSCs) take on the role of scrutiny of the NHS including major changes in services and ongoing operation and planning of current services. They bring democratic accountability to healthcare decisions and make the NHS more publicly accountable and responsive to their local communities.

The Staffordshire OSC formed local OSCs for each district council area. None of the OSCs concerned (Staffordshire, Cannock Chase and Stafford) reported receiving any significant complaints about Mid Staffordshire hospital trust although there were some concerns about the cleanliness of the hospital and about hospital acquired infections. The former improved and the hospital had a clear approach to tackle the latter. Only when the Healthcare Commission began its investigations did local councillors in Stafford begin to vocalise significant but disturbing concerns about care quality.

We need to make more use of councillor feedback in future, as like GPs, they are the 'eyes and ears' of their communities.

Conclusion

Looking back to 2002 through my review, I was hampered by a lack of organisational memory. While health systems need to adapt and change, both the old and the new management structures did not do enough to hand over knowledge and information.

There was also an obvious lack of clarity over the respective roles and responsibilities of each of the organisations with an over reliance that another organisation was responsible for identifying, and acting on concerns, which when they did not, allowed failure to continue.

World class commissioning places a clear responsibility on PCTs as commissioners to act as local leaders of the NHS, and gives a greater clarity to their central role and responsibility in ensuring quality and safety of patient care. PCTs are ultimately responsible for commissioning safe services and improving the health of their patients and local populations. This clarity was needed and provides the basis for acting on the recommendations in my report. It must be backed up by good working relationships between all organisations, and PCTs must take responsibility for discharging their leadership role through partnership, especially with clinicians, providers and their patients and populations.

Recommendations

- 1. PCTs as local leaders of the NHS must assume ultimate responsibility for commissioning safe services and improving the health of their patients and populations.**
- 2. All hospital providers including foundation trusts must allow PCTs ready access to review their services.**
- 3. SHAs are the regional headquarters of the NHS, and in that role must ensure that the whole healthcare system discharges its responsibilities, with a particular emphasis on the performance management of PCTs to ensure that they are taking forward their leadership role. The Commissioning Assurance System for world class commissioning provides a framework for taking this forward.**
- 4. PCTs and SHAs must be more proactive in informing Monitor of any concerns prior to foundation trust application and not assume that the regulators will take responsibility for ensuring quality of care. The regulators must share data and early concerns to allow PCTs and SHAs to take action.**
- 5. The Department of Health should describe how the roles of PCTs, SHAs and the regulators are different and how they interrelate.**
- 6. The Department of Health should set out clear expectations on all health organisations that effective 'business continuity planning' is the norm, and work in co-production with the NHS to develop guidance for organisational transition, including effective formal record keeping.**
- 7. The NHS Confederation should consider how it can support PCTs through its network to develop their capacity and capability to respond to their role as local leaders of the NHS following lessons to be learnt from this review.**

Clinical leadership

Effective clinical leadership at all levels of the NHS from where patients are treated and cared for right up to the board of an organisation, is an essential pre-requisite of a safe, high quality and effective service. In Mid Staffordshire hospital trust, this was lacking. It could also have been more effective in the PCTs and SHAs.

Evidence

Clinical governance within the trust was poor and clinicians did not raise concerns about the poor quality of care for patients. In particular, nursing care was found to be wanting. Most of the patient complaints about the hospital care were focused on poor nursing quality and attitudes, and also related to inadequate staffing levels. Resourcing staffing levels is a management responsibility, but where inadequate numbers are impacting on the quality of patient care, clinicians have a duty to raise their concerns. Staffing levels at Mid Staffordshire hospital trust were noted in the CHI clinical review in 2002 and also in staff surveys from 2006.

The responsibility for ensuring a suitably staffed service rests primarily with the provider of the service, but the commissioner has a responsibility to be aware of workforce issues both through risk management and through performance management roles. The PCTs did not gain the assurance that the staffing models were sufficient to uphold quality standards for patient care.

The SHA, in their oversight role across the health economy, could also have been more aware.

Clinical leadership within the PCT was present, but there is still room for improvement. Whilst clinicians are represented on the PCT board, the current arrangement at South Staffordshire PCT is that of a combined post of medical director and Professional Executive Committee (PEC) Chair. This may dilute the clinical input.

Before 2006, PECs were seemingly not an effective force in the Staffordshire PCTs and their role was unclear. In addition, although practice based commissioning was in place, it was limited in its scope. This was partly due to its relatively new introduction nationally, but highlights the limited methods of powerful clinical leadership and engagement methods at the time. Since 2006, local practice based commissioning arrangements have been strengthened. However, these did not translate into escalation of concerns about the care at Mid Staffordshire hospital trust.

Conclusion

As a clinician myself, I feel very passionately that clinicians must play a crucial role in protecting patients' interests and leading on quality in the NHS, both in direct care of patients and at every management level through to senior board level roles. Many clinicians continue to practice at the same time as they take on senior roles, giving them a unique insight into both care and management of health services. PCTs and SHAs need to ensure that the clinical voices they are hearing are strong and are connecting to patients. I also want to stress the importance and uniqueness of the Practice Based Commissioning role in making patient voices heard, systematising the GPs role as the 'eyes and ears' of their communities and in improving effectiveness and quality of care both in primary care and in hospital and community based services.

Good practice exists, for example:

NHS Barnsley PCT has a director of nursing and medical director for each of primary and secondary care. The PCT has a clinical governance committee and provider governance committee with significant substructure and resource. The PEC sets the standards to ensure safe patient care on behalf of the PCT.

Stockport NHS Foundation Trust employs a consultant epidemiologist who takes a role in upholding clinical quality and safety at the trust. Using networks across acute and primary care trusts, they lead on work reviewing clinical outcome indicators and investigate mortality alerts.

Recommendations

- 1. PCTs should review their clinical leadership arrangements at board level to ensure that they are effective. Separate responsibility for medical and nursing director input at board level should exist with a remit to ensure clinical quality across the whole healthcare system on behalf of the PCT.**
- 2. PCTs should review the effectiveness of their Professional Executive Committee (PEC) as advisors to the PCT board, and in particular the role of the PEC in quality assurance.**
- 3. PCTs should further support the development of practice based commissioning and should be held to account for doing so through the Commissioning Assurance System within world class commissioning.**
- 4. PCTs should take greater responsibility for awareness of provider staff issues e.g. staffing levels and quality of care, through their risk management and performance management roles in commissioning.**
- 5. All clinicians must speak up for patients when they witness poor quality care. It is our overarching duty.**

Annex A – timeline of events 2002-2007

January 2002	Commission for Health Improvement (CHI) publishes clinical governance report on Mid Staffordshire Hospital.
July 2002	Trust awarded 2 star rating by CHI.
July 2003	Trust awarded 3 star rating by CHI.
July 2004	Trust awarded 0 star rating by Healthcare Commission.
July 2005	Trust awarded a 1 star rating by Healthcare Commission.
June 2005	Chief Executive David O'Neill leaves Mid Staffordshire hospital Trust. Martin Yeates appointed Chief Executive and starts in September.
July 2006	West Midlands SHA is formed, following a reconfiguration of the SHAs Shropshire and Staffordshire, Birmingham & The Black Country and West Midlands South.
October 2006	South Staffordshire PCT is formed, following reconfiguration of Burntwood, Lichfield & Tamworth, Cannock Chase, East Staffordshire and South Western Staffordshire PCTs.
October 2006	Mid Staffordshire hospital trust assessed as Fair-Fair in 2005/06 Annual Health Check.
March 2007	Healthcare Commission national staff survey for 2006 is published, showing 27% of staff say they are happy with the care at the Mid Staffordshire hospital Trust.
April 2007	Dr Foster's Good Hospital Guide classifies Mid Staffordshire hospital trust as having high mortality rates.
Summer 2007	Healthcare Commission reviewed core standards at Mid Staffordshire hospital trust
October 2007	Mid Staffordshire hospital trust assessed as Good-Fair in 2006/07 Annual Health Check.
February 2008	Mid Staffordshire hospital trust formally awarded foundation trust status by Monitor.
March 2008	Healthcare Commission launches a formal investigation into mortality rates at Mid Staffordshire NHS Foundation Trust.
September 2008	Healthcare commission press release notes that the Foundation Trust has responded positively to concerns that the Commission had raised about the safety of patients in Stafford Hospital's accident and emergency department (A&E). The trust has improved medical staffing levels and increased the numbers of nurses in A&E.
Autumn 2008	Mid Staffordshire NHS Foundation Trust introduces new model of care in A&E, new triage system, more training for staff.

October 2008	Healthcare Commission provisionally rate the Trust Good-Good in their 2007/2008 Annual Health Check. The quality rating was later re graded to “weak”.
October 2008	Healthcare Commission investigation phase completed.
November 2008	Dr Foster’s 2008 Hospital Guide classifies Trust as having significantly higher than expected mortality rates.
3 March 2009	Chair and Chief Executive stand down. An interim Chair (David Stone, Chair of Sheffield Teaching Hospitals NHS FT) takes up post with immediate effect.
5 March 2009	Interim Chief Executive (Eric Morton Chief Executive of Chesterfield Royal Hospitals NHS Foundation Trust) is appointed.
17 March 2009	Healthcare Commission publish the report of their investigation.
24 March 09	Healthcare Commission re grade Annual Health Check assessment of quality to weak.

Annex B - Acknowledgements

In gathering the evidence for this review and forming my recommendations, I have undertaken a series of visits, discussions and reviewed key documents. There have been many individuals who have provided expert advice, all in a frank and open way, despite the high profile and media scrutiny surrounding the issue. I would like to thank all those who have supported me in developing this review.

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Brian Ferguson, Director of Yorks & Humber Public Health Observatory

Stephen Watkins, Director of Public Health Stockport PCT and FT

Ian Rutter, GP, DH adviser and former PCT CE (who also accompanied on visits)

Steve Field, GP, Chairman RCGP and PGD West Midlands

John Ashton, Director of Public Health, Cumbria PCT

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Jan Sobieraji, Sheffield CE

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Richard Barker, Director of Operations, North East

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Other

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Regulators

Baroness Barbara Young, Chair Care Quality Commission
Anna Walker, CE of Former Health Care Commission
Bill Moyes, Chair, Monitor
Adrian Masters, Director of Strategy, Monitor
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Stephen Hay, Chief Operating Officer, Monitor
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Links to Mid Staffordshire

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Cynthia Bower, CE, CQC
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Moira Dumma, Deputy Chief Executive Officer, SHA (2004-2006)
Mike Brereton, Chairman of SHA (2002 – 2006)
Judith Wright, Former Director of Public Health, Cannock Chase PCT (2004–2006)
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Jan Warren, Former Director of Primary Care and Professional Development (2002–2006)
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Steve Shilrock, Overview and Scrutiny Committee, Cannock Chase District Council
Andy Bailey, Overview and Scrutiny Committee, Stafford Borough Council
Steve Powell, Business Partner at Weeping Cross & Beaconside Health Centres, Stafford and Chair of Stafford and Surrounds Practice Based Commissioning Group.
Dr Anne-Marie Houlder, G.P Partner at Mansion House Surgery, Stone and Clinical Lead for Stafford and Surrounds Practice Based Commissioning Group

Annex C – Examples of best practice

Involving public and patients

Luton and Dunstable NHS hospital foundation trust invites patients with complaints to present to their board.

Tower Hamlets PCT has a service alert process where GP practices submit concerns about individual patient care to the acute trust, and this is monitored by the PCT and practice based commissioning groups.

NHS Sheffield has in place monthly 'patient stories' sessions where patients are invited to share their experiences of care directly with the PCT.

NHS Cumbria employ community engagement staff who meet regularly with LINK, Patient Voice group, Neighbourhood fora and other local groups to understand people's experience and perceptions of local health services.

Commissioning for outcomes supported by excellent use of appropriate data and information

Oldham PCT's Advancing Quality Programme measures three quality indicators – clinical outcomes, patient reported outcomes and patient experience. It triangulates these sources and offers financial incentives for the top hospitals achieving against these indicators.

NW SHA are taking a whole system approach to developing more locally owned and delivery standards focusing on quality. These will be defined by front line staff, drawing on the NW's Advancing Quality programme, and will be reviewed every six months and progress against them publicly reported.

NHS Sheffield has a clinical assurance tool, which reviews risk and quality standards. They also have patient and staff surveys at ward level, which they triangulate, with staffing levels and bed occupancy.

Wirral Hospital NHS trust employs a consultant grade doctor as head of the clinical practice research unit accountable to the medical director and reporting to the clinical effectiveness committee.

Central Manchester NHS Foundation Trust uses the Intelligent Board Scorecard which is a dashboard of indicators which are continually updated and include measures of patient experience, clinical effectiveness and quality.

National Patient Safety Agency uses Never Events which were mentioned in High Quality Care for All.

<http://www.npsa.nhs.uk/nrls/improvingpatientsafety/neverevents/the-policy/>

They also use the National Reporting and Learning System which captures patient safety incident reports from all NHS organisations across England and Wales. It was set up in 2003 and now holds over three million incident reports.

And, they have a Patient Safety First Campaign jointly with National Institute for Innovation and Improvement and the Health Foundation incorporating the innovative 'global trigger tool'.

Clinical leadership

NHS Barnsley PCT has a director of nursing and medical director for each of primary and secondary care. The PCT has a clinical governance committee and provider governance committee with significant substructure and resource. The PEC sets the standards to ensure safe patient care on behalf of the PCT.

Stockport NHS Foundation Trust employs a consultant epidemiologist who takes a role in upholding clinical quality and safety at the trust. Using networks across acute and primary care trusts, they lead on work reviewing clinical outcome indicators and investigate mortality alerts.

Annex D – Acronyms

PPE	Patient and Public Experience
FT	Foundation Trust
CQC	Care Quality Commission
CLG	Department for Communities and Local Government
NHSI	National Health Service Institute
PBC	Practice Based Commissioning
LMC	Local Medical Council
PALS	Patient Advice and Liaison Services
CHI	Commission for Health Improvement
PEC	Professional Executive Committee
HSMR	Hospitalised Standardised Mortality Rates
A&E	Accident and Emergency
HCC	Health Care Commission
PPI	Patient and Public Involvement
LINKs	Local Involvement Networks
PCT	Primary Care Trust
SHA	Strategic Health Authority
WCC	World Class Commissioning
OSC	Overview and Scrutiny Committees
NPSA	National Patient Safety Agency
CE	Chief Executive
SoS	Secretary of State