Executive summary

Introduction

The purpose of the Inquiry

1. Concerns about mortality and the standard of care provided at the Mid Staffordshire NHS Foundation Trust resulted in an investigation by the Healthcare Commission (HCC) which published a highly critical report in March 2009. This was followed by two reviews commissioned by the Department of Health. These investigations gave rise to widespread public concern and a loss of confidence in the Trust, its services and management.

2. This Inquiry was set up by the Rt Hon Andy Burnham MP, Secretary of State for Health, primarily to give those most affected by poor care an opportunity to tell their stories and to ensure that the lessons to be learned from those experiences were fully taken into account in the rebuilding of confidence in the Trust. The period reviewed by the Inquiry was principally January 2005 to March 2009.

3. The terms of reference also allowed the Inquiry to gather the views and experience of the staff at the Trust and to seek explanations from management, including the directors, for what happened. It was not the intention that the Inquiry should be a forum for bringing individuals to account but the opportunity has been taken to examine the processes of accountability.

4. There has been considerable public concern about the significance of the mortality statistics which prompted the HCC's investigation. The Inquiry undertook a consideration of the significance to be attached to these figures.

5. The Inquiry was urged to investigate the role of a number of external agencies in the failure to detect and act on the deficiencies revealed by the HCC investigation, but the terms of reference set did not permit it to do so. It has, however, received a considerable body of opinion on that issue.

Methodology and material considered

6. The Inquiry Chairman invited assistance from a panel of specialist advisers and had the benefit of advice and submissions from Counsel to the Inquiry. Cure the NHS, a group representing the vie ws of a number of patients and their families with complaints about the Trust, was invited to contribute to the Inquiry as an interested party. Its legal representatives were accorded observer status at hearings, as were representatives of the Trust, the Primary Care Trust (PCT) and

the strategic health authority (SHA). Observers were only permitted to be present at a hearing when the witness attending agreed. All hearings were held in private, but summaries of the evidence heard were posted regularly on the Inquiry's website.[1]

7. Documentary material was obtained from a wide variety of sources, including the Trust, the PCT and other NHS bodies, the Care Quality Commission (successor to the HCC), the SHA, Monitor, Cure the NHS, the local authorities and the four local Members of Parliament, who had all been approached by constituents with concerns.

8. When the Inquiry was set up, it was envisaged that it would have the benefit of reports on individual cases that had been reviewed by the independent case notes review being conducted under the auspices of the PCT. It emerged that the review was not expected to complete its work until March 2010 and therefore outside the timescale of this Inquiry. It was, however, possible to receive copies of notes and, in some cases, records of interviews with patients and their families from the review, where those seeking the review consented.

9. The Inquiry was contacted, directly or indirectly, by 966 individual members of the public and some 82 members of Trust staff, past and present. The majority of the members of public expressed concerns about the care received and observed at the Trust, but a substantial minority had only positive comments to make. The Inquiry also received representations from a wide range of organisations, including professional bodies and patient interest groups.

10. It was not possible for the Inquiry to see all those who had contacted it at an oral hearing. The general themes arising out of the written material were identified and a selection made of cases that appeared illustrative of a theme, or raised points of particular interest, required clarification or for some other reason would assist the Inquiry in its task. Members of staff, past and present – including a number who had not contacted the Inquiry, were also invited to attend oral hearings. These included executive and non-executive directors who had been in post during the period under review.

11. With one exception, all those members of staff who were invited to attend an oral hearing did so. The exception was Mr Yeates, the former Chief Executive, who I was satisfied on medical evidence, including independent medical advice commissioned by the Inquiry, was unfit to attend. However, some written material was furnished on his behalf. In total, the Inquiry heard oral evidence from 113 witnesses.

[1] http://www.midstaffsinquiry.com

General approach

12. It was not the intention of the Inquiry to re-investigate the findings of the HCC, but it has been necessary to look at some of the areas the HCC considered. The report is not intended to cover every area considered in the HCC report but has been led, to a significant extent, by the evidence the Inquiry has received. The intention has been to look at sufficient areas to enable a picture to be developed of the deficiencies that have been suffered by patients during the period under review and the systemic failings which led to them.

13. In addition to considering the detail of the stories of those who gave oral evidence, it was thought essential that the accounts given to the Inquiry by all who had concerns about the care provided should be acknowledged and summarised in the report to provide a record from which all who read it could learn and promote acceptance of the true scale of the deficiencies at the Trust. Therefore, a separate and substantial volume is devoted to summaries of the accounts received of concerns from the members of the public who made contact with the Inquiry.

14. In general, individuals have not been identified in the report to protect their privacy and rights to confidentiality, but Board members, past and present, are identified.

The patient experience

15. The Inquiry received complaints about care in many parts of Stafford Hospital and occasionally at Cannock Chase Hospital. The complaints were predominantly focused on the accident and emergency (A&E) department, the emergency assessment unit (EAU) and Wards 7, 8, 10, 11, and 12. It was striking how many accounts related to basic nursing care as opposed to clinical errors leading to injury or death.

16. In very few cases did the Inquiry hear from members of staff about their recollection of or explanations for the specific incidents recounted by patients and their families. This was not an adversarial process in which the truth and reliability of witnesses was tested as would have occurred in a traditional 'trial'. Nonetheless, the quality of the evidence given by patients and their families, the dignity and care with which they did so, and the sheer number of similar accounts was highly persuasive. There is no reason to doubt that in the vast majority of cases events occurred as they have been described. Many of the complaints had been made to others before the HCC report was published and therefore were not affected by its influence. The evidence was quite sufficient to establish that what we heard provided a fair account of the standards of care being provided at the times described.

17. The experience of listening to so many accounts of bad care, denials of dignity and unnecessary suffering made an impact of an entirely different order to that made by reading written accounts. All those who were present at oral hearings were deeply affected by what they heard. One of the purposes of setting out summaries not only of the oral accounts but also of the written accounts received in volume 2 has been to assist in the understanding of what occurred, and to promote good standards of care in the future. It is hoped that it will also provide a public acknowledgement of the important contribution to the Inquiry made by these witnesses and to allow their voices to be heard by those with responsibility for delivering care at these and other hospitals. This material should also assist the Trust's staff, individually and collectively, to acknowledge and accept that the care provided in the past often fell far below an acceptable standard.

18. The areas in which detailed accounts were heard by the Inquiry included:

- continence and bladder and bowel care;
- safety;
- personal and oral hygiene;
- nutrition and hydration;
- pressure area care;
- cleanliness and infection control;
- privacy and dignity;
- record keeping;
- diagnosis and treatment;
- communication; and
- discharge management.

Continence and bladder and bowel care

19. Of the 33 cases of which oral evidence was heard, 22 included significant concerns in this category. Requests for assistance to use a bedpan or to get to and from the toilet were not responded to. Patients were often left on commodes or in the toilet for far too long. They were also often left in sheets soiled with urine and faeces for considerable periods of time, which was especially distressing for those whose incontinence was caused by *Clostridium difficile*. Considerable suffering, distress and embarrassment were caused to patients as a result.

20. There were accounts suggesting that the attitude of some nursing staff to these problems left much to be desired. Some families felt obliged or were left to take soiled sheets home to wash or to change beds when this should have been undertaken by the hospital and its staff. Some staff were dismissive of the needs of patients and their families.

21. The omissions described left patients struggling to care for themselves; this led to injury and a loss of dignity, often in the final days of their lives. The impact of this on them and their families is almost unimaginable. Taken individually, many of the accounts I received indicated a standard of care which was totally unacceptable. Together, they demonstrate a systematic failure of the provision of good care.

22. The causes of these instances of poor care included, in a small number of cases, staff who appeared uncaring. More often there were inadequate numbers of staff on duty to deal with the challenge of a population of elderly and confused patients. There may also have been a lack of training in continence care and difficulties may have been compounded some of the time by infection control problems. It is difficult to believe that lapses on the scale that was evidenced could have occurred if there had been an adequately implemented system of nursing and ward management.

Safety

23. The Inquiry received striking evidence about the incidence of falls, some of which led to serious injury. Many, if not all, took place unobserved by staff and too many were not reported to concerned relatives for too long, or only when they saw an injury for themselves. Recording of falls was of questionable accuracy. The Inquiry heard of an instance of a patient suffering a series of falls unobserved, finally sustaining a fatal injury.

24. Confused patients can be a threat to themselves and others in their ward. The Inquiry heard evidence of threats and even assaults by such patients taking place before any intervention by staff.

25. The reason for the incidence of falls and other safety concerns was probably attributable to a combination of a high dependency level among the mix of patients combined with too few staff, or staff not sufficiently qualified to cope. Incidents of the type described to the Inquiry should not have been able to happen or continue more than momentarily if proper risk assessment and observation were applied.

Personal and oral hygiene

26. The Inquiry heard of many cases in which relatives had to spend extended periods attending to their relatives' hygiene needs. This included having to get the patient to and from the bathroom, washing, and attending to other personal care needs. Little assistance was offered in such cases, and there was a fear that if families did not attend to such care the staff would not do so. The accounts included cases of patients who had soiled themselves who were dependent on their relatives to clean them.

27. The evidence included complaints about the poor hygiene practice of staff when they did attend to the washing of patients. Bad practice observed included using a razor on more than one patient, and the use of a shared bowl for washing. The Inquiry heard several accounts of poor mouth care in which mouthwash was not provided for patients with mouth ulcers, and neglect of basics such as cleaning teeth and rinsing out of dried mouths. A particular concern for a number of elderly female patients was the failure, in some cases, to wash and brush patients' hair.

28. Failure to ensure a proper level of personal cleanliness and hygiene degrades patients, aggravating the feelings of illness, disability and separation from home and familiar surroundings. A wholly unacceptable standard was tolerated on some of the Trust's wards for a significant number of patients.

Nutrition and hydration

29. About half the patients and their families who gave oral evidence provided accounts of issues with obtaining appropriate food and drink. The concerns raised included:

- lack of menus;
- provision of inappropriate food for patients' conditions;
- failure to provide a meal;
- meals placed out of reach and taken away without being touched;
- patients not helped to unwrap the meal or cutlery;
- patients not encouraged to eat;
- relatives and others denied access at mealtimes;
- visitors having to assist other patients with their meals;
- visitors prevented from helping feeding;
- water not available at the bedside;
- water intake not encouraged or monitored;
- drips not monitored adequately; and
- monitoring and appropriate records of fluid balance not maintained.

30. The provision of food and water is one of the most basic responsibilities of a hospital and its staff. Patients are often unable to provide for themselves. Each patient requires individual consideration. The deficiencies observed in the evidence were not confined to one ward or period. Frequently the explanation appears to have been a lack of staff, but sometimes staff were present but lacked a sufficiently caring attitude. There was evidence of unacceptable standards of care as a result of systemic failings. What has been shown is more than can be explained by the personal failings of a few members of staff.

Pressure area care

31. Some 20 people who contacted the Inquiry complained of bad experiences with pressure sores. Their stories suggested a lack of care; these stories were not surprising given the general description of care afforded at times. Shortage of staff and other obstructions made it inevitable that there would be cases of avoidable skin breakdown. It is doubtful whether assessment techniques were used consistently, and there seems to have been little multidisciplinary team working.

Cleanliness and infection control

32. Many witnesses remarked on the lack of appropriate cleaning in wards and facilities resulting in patients being left in a dirty state. There was also evidence of poor hygiene practice, including using the same cloth to clean ward surfaces and toilets. Hand gel containers were often left empty. Rooms vacated by patients with C. difficile were not cleaned before the next patient was admitted. Witnesses also complained of a lack of information about what precautions should be taken. The evidence heard by the Inquiry suggests that the deficiencies identified have not been isolated mistakes or lapses restricted to one place or one time.

Privacy and dignity

33. Many of the accounts of the patient experience at the Trust described clearly impacted on patients' dignity. There were notable causes for concern which included:

- incontinent patients left in degrading conditions;
- patients left inadequately dressed in full view of passers-by;
- patients moved and handled in unsympathetic and unskilled ways, causing pain and distress;
- failures to refer to patients by name, or by their preferred name; and
- rudeness or hostility.

34. However difficult the circumstances, there is no excuse for staff to treat patients in the manner described by some witnesses to the Inquiry. Respect for dignity must be a priority of care and must be at the forefront of clinicians' minds.

Record keeping

35. The Inquiry has examined a wide range of medical records and has heard from patients and their families of concerns they had about record keeping. A number of common deficiencies were observed, including:

- no clear registration of patients' transfer from one ward to another;
- no consistent use of care plans;
- incomplete nursing records;
- lack of appropriate nutrition and hydration charts;
- sparse details of social history, past medical history and other important background information;
- authors of records not clearly identifying themselves;
- failure to record assessment scores; and
- inaccurate recording of time of death.

36. A number of relatives told of how they altered or completed records themselves on finding inaccuracies.

Diagnosis and treatment

37. The Inquiry heard of a number of cases of clear misdiagnosis, including a case of a failure to diagnose a serious injury in a young man who later died as a result. There were also cases involving delayed diagnosis. In some cases, families were not listened to during the diagnostic process. The Inquiry heard of failure to follow up investigations and a lack of communication between staff about what needed to be done. The manner of communicating serious diagnosis to patients sometimes left a lot to be desired. A common complaint was of a long wait between assessments and the communication of a diagnosis.

38. Mistakes in diagnosis are inevitable sometimes. Whether or not they are avoidable, they are always likely to be detrimental to the patient and knowledge of the mistake will add to his or her distress.

Communication

39. A very significant number of patients gave accounts of poor standards of communication; the concerns raised included:

- lack of compassion for patients or lack of reassurance that staff cared;
- lack of information about patients' care or condition;
- lack of involvement in decisions;
- insensitivity;
- reluctance to give information;
- failure of communication between staff;
- provision of wrong information;
- failure to listen; and
- lack of engagement with families and friends.

40. The provision of the right information to patients and their families at the right time is vital. This requires staff to possess it, and pass it on to colleagues to ensure continuity and consistency. Information needs to be delivered with sensitivity and due regard for the patients as valued individuals.

Discharge management

41. Patients and their families complained to the Inquiry in 96 cases about matters connected with discharge from hospital. The principal issues raised have been:

- discharge from A&E without appropriate diagnosis or management;
- premature discharge from wards;
- protracted discharge processes;
- failure to communicate arrangements to patients and their families;
- discharge at an inappropriate time or in an inappropriate condition; and
- failure to ensure adequate support.

42. There is an impression that community support services may not be entirely satisfactory, but the burden of the complaints raised matters that can and should be addressed within a hospital. The pressure to discharge patients from wards to accommodate the patient intake from A&E should not be allowed to be a factor in influencing the decisions of managers and clinicians to discharge patients who are not ready. Adequate arrangements and warning of discharge must be provided. Any waiting area designed for discharged patients should be properly equipped to cater for their needs.

The culture of the Trust

43. The culture of the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff. A number of factors contributed to this:

- **attitudes of patients and staff** – patients' attitudes were characterised by a reluctance to insist on receiving basic care or medication for fear of upsetting staff. Although some members of staff were singled out for praise by patients, concerns were expressed about the lack of compassion and uncaring attitude exhibited by others towards vulnerable patients and the marked indifference they showed to visitors.
- **bullying** – an atmosphere of fear of adverse repercussions in relation to a variety of events was described by a number of staff witnesses. Staff described a forceful style of management (perceived by some as bullying) which was employed on occasion.

- **target-driven priorities** – a high priority was placed on the achievement of targets, and in particular the A&E waiting time target. The pressure to meet this generated a fear, whether justified or not, that failure to meet targets could lead to the sack.
- **disengagement from management** – the consultant body largely dissociated itself from management and often adopted a fatalistic approach to management issues and plans. There was also a lack of trust in management leading to a reluctance to raise concerns.
- **low staff morale** – the constant strain of financial difficulties, staff cuts and difficulties in delivering an acceptable standard of care took its toll on morale and was reflected by absence and sickness rates in particular areas.
- **isolation** – there is a sense that the Trust and its staff carried on much of its work in isolation from the wider NHS community. It was not as open to outside influences and changes in practice as would have been the case in other places and lacked strong associations with neighbouring organisations.
- **lack of openness** – before obtaining Foundation Trust status, the Board conducted a significant amount of business in private when it was questionable whether privacy was really required. One particular incident concerning an attempt to persuade a consultant to alter an adverse report to the coroner has caused serious concern and calls into question how candid the Trust was prepared to be about things that went wrong.
- **acceptance of poor standards of conduct** – evidence suggests that there was an unwillingness to use governance and disciplinary procedures to tackle poor performance. The Inquiry has heard of particular incidents of apparent misconduct which were not dealt with appropriately, promptly or fairly.
- **reliance on external assessments** – The evidence indicates that the Trust was more willing to rely on favourable external assessments of its performance rather than on internal assessment. On the other hand when unfavourable external information was received, such as concerning mortality statistics, there was an undue acceptance of procedural explanations.
- **denial** – In spite of the criticisms the Trust has received recently, there is an unfortunate tendency for some staff and management to discount these by relying on their view that there is much good practice and that the reports are unfair.

The experiences and perceptions of staff

Accident and emergency

44. A&E was chronically understaffed in terms of consultants and nurses during the period under review. There were frequent changes in management, which led to a sense of lack of leadership and support of staff. The perception of weak clinical leadership within A&E held by some was unfair to one consultant on whom undue burdens were placed. When more consultants were recruited to ease the pressure,

they were emergency physicians who were not qualified to undertake the whole range of A&E duties. The drive to meet the waiting time target had a detrimental effect on staff and on the standard of care delivered. There was persuasive evidence that this even led to attempts to fabricate records.

Emergency assessment unit

45. The evidence from patients and their families presented a mixed picture of the EAU, but staff consistently described the ward in pejorative terms. The pressure of working there was felt by some to be intolerable.

Other wards

46. Staff evidence tended to confirm the concerns raised by patients and their families. Among difficulties described were problems in locating a nurse to accompany ward rounds, the pressure from high-dependency patients and the dilution of skills that resulted from reconfiguration. Understaffing was a constant problem and staff even expressed fear about losing their registration because of the unsafe care delivered. Concerns were also expressed about the inappropriate mix of patients on the surgical floor.

The management of significant issues

47. The Inquiry has examined how particular issues were dealt with by management.

Ward reconfiguration

48. Staff perceived this scheme, to reconfigure the wards onto three floors, one surgical and two medical, as a means to reduce costs and staff. This was denied by those who proposed the scheme, but it is significant that at the time the initial proposal was approved savings were prominently identified. The minutes of the Board suggest that finance was a crucial factor. It was acknowledged by all concerned that the success of the scheme was dependent on achieving the correct levels of staffing.

49. There does not appear to have been an evidence base for the changes that were made. The attraction of the advantages – the financial savings – discouraged proper attention being paid to the disadvantages. The EAU was established as part of the first part of the reconfiguration project. Many who worked there regarded the level of staffing as inadequate, a view not shared by the Director of Clinical Standards. The surgical floor was set up without any evidence that a risk assessment of the necessary changes was actually carried out, although the need for it was recognised. Concerns expressed by staff at the time about the proposal were welcomed by directors but were not addressed.

50. The Inquiry could not trace any record of the medical floors part of the plan being considered or approved by the Board. In particular, the changes of nursing skill mix, which resulted in a predominance of healthcare assistants over qualified nurses, are not recorded in any Board minute seen by the Inquiry. There were differences of account between executive directors as to who was involved in the decision and the change was disowned by the Director of Clinical Standards, and only nurse on the Board, in evidence to the Inquiry. There was a concerning lack of clarity about the process by which this important decision was taken.

51. Once implemented, the medical floors scheme met with widespread disapproval from staff. The evidence strongly suggests that the whole clinical floors project was planned and implemented without due regard to staff's legitimate concerns and without monitoring by the Board of the effectiveness of the scheme once implemented.

Finance

52. Much of management thinking during the period under review was dominated by financial pressures. The Trust had been facing financial problems for some time before the period under review, with frequent annual deficits. However, a crisis developed at the end of the 2006/07 financial year which led to a need to find cuts of £10 million. It is by no means clear that the only way of finding the necessary savings was to implement a workforce reduction programme. It certainly need not have happened without the involvement of staff and the various departments. Instead, a top-down proposal was launched with departments having to identify cuts to fit the predetermined budget.

Implementation of staff cuts

53. The Trust has yet to recover fully from the impact of the staff cuts and changes to skill mix. When these changes were made, the Trust did not have sufficient information about the funded establishment to enable properly informed decisions to be taken. The workforce reduction proposal in 2006 was accompanied by what was called a risk assessment, but on the documents seen by the Inquiry this was superficial and inadequate. The minutes of the Hospital Management Board do not suggest that there was any detailed scrutiny of how the assessment was performed and of its significance. It is also unclear what, if any, engagement executive directors had in this process. When there was a change in Directorship of Clinical Standards/Nursing in December 2006, the new incumbent immediately recognised the need for a workforce review. When completed, it became clear that far from being overstaffed at the time of the workforce reduction the Trust had been understaffed with nurses.

Workforce review

54. The review, the need for which was identified in December 2006, was not completed until March 2008. No satisfactory explanation has been given for why it took so long. Even when the findings of the review were received the Board did not react to it with great urgency, seeking to fund the necessary increase in staff in stages, which are still incomplete. The ramifications of this in terms of the standard of care it was possible to deliver appear not to have been sufficiently appreciated.

Governance

55. In 2002, the Commission for Health Improvement (the predecessor of the HCC) reported that the Trust lacked effective clinical governance. This had not been corrected by the beginning of the period under review. The new Chair who arrived in August 2006 understood this deficiency existed and the need to remedy it. Part of her solution was to pursue Foundation Trust status as a driver for improvements in governance. The structure had several layers of management between divisional governance groups and the Board. The Medical Director and the Director of Nursing were the only two routes through which clinical or nursing concerns were likely to reach the Board. Higher level committees focused on financial matters and did not appear to have been receiving or addressing clinical issues as a priority.

56. Clinical audit was poorly developed at the Trust. Many individual clinicians were reluctant to engage in it and there was a lack of resources and support for those who did.

57. Incident reporting systems were criticised by many staff, in particular because of the lack of feedback and because reports attributing incidents to staffing issues were perceived to be discouraged. These factors led some staff to be reluctant to file incident reports. There was, at least for a time, a lack of clarity about the requirements for filing a serious untoward incident report. The Inquiry found evidence that a number of deaths which led to inquests had not been reported in this system when they should have been.

58. The investigation of complaints was frequently delegated to staff in the area with which the complaint was concerned. This could result in defensive rather than constructive reports which lacked credibility with complainants who perceived them to lack impartiality. Replies to complaints were often provided too slowly and did not always address all the issues raised. There was a formulaic approach which appeared to value process over substance. Apologies when offered were not always well thought out. Staff who were the subject of complaints did not always have the full details put to them, devaluing any investigation.

59. A particularly disturbing feature of the complaints process was that the Trust often did not apply effective remedial action. This is evidenced by a series of complaints raising similar issues in which the response each time was an action plan which, if implemented, would have avoided a subsequent incident. It is difficult to understand how the Chief Executive, if he read the complaints, could have been unaware of systemic failings in the delivery of care. Some letters acknowledged multiple failings. There is no evidence that the substance of complaints were reported to the Board. If they had been told of some of the experiences of those who complained, they would not have been as shocked as they were when finally members of Cure the NHS were able to speak to them directly.

60. A poor complaints system has a negative impact on the patients and others who seek to use it. Inadequate responses cause distress and may exacerbate bereavement. Complainants are left desperate for answers to their questions. While the Board received reports of themes of complaints, these were too broad to be informative. With a serial filtering of information with no involvement from non-executive directors, the Board was distanced from the reality of complaints.

61. Appraisal and professional development were accorded a low priority, as indicated by national surveys. There was evidence that staff were not supported by a robust appraisal system and that continuous professional development was sporadic. There was also evidence of a reluctance to take robust disciplinary action where this appeared to be needed. Concerning cases of alleged misconduct and deficient performance have either not been addressed at all or only in a hesitant manner. This is starkly evidenced by two Royal College of Surgeons' reviews of the hospital's surgical division and the dysfunction brought to light by them.

62. The few instances of reports by whistleblowers of which the Inquiry was made aware suggest that the Trust has not offered the support and respect due to those brave enough to take this step. The handling of these cases is unlikely to encourage others to come forward, and the responses to the investigation of the concerns raised have been ineffective.

The Board

63. The Inquiry examined the experience of Board members during the period under review together with their explanations of what happened and their reactions to the HCC report. It also examined the process leading up to the departure of the Chair and Chief Executive in March 2009. It was noted that the non-executive directors recruited by the Trust were on the whole inexperienced in NHS board positions. While this may be inevitable in a relatively small trust, it does give rise to a need to call on more training or outside assistance.

64. The codes of conduct and guidance for directors make it clear that their duty is to provide strategic direction and that they should refrain from intervening in operational detail, but that they are collectively accountable for all aspects of the performance of the Trust. The Board may have interpreted the division between the strategic and the operational too rigidly, particularly at a time when they were aware that there were serious deficiencies in the governance structure. They may have failed to understand that in such circumstances there will be many instances when a non-executive director can only understand the issues by being informed of operational detail.

65. The styles and characteristics of various Board members may help to explain how they functioned as a group. The Chair throughout the relevant period was a strong leader with a clear vision admired by her colleagues. The clinicians taking the role of medical director were reluctant recruits to part-time posts. They may have been handicapped in presenting the professional view to the Board by the disinclination of consultants to engage with management issues. They were not natural leaders and lacked an external perspective which might have alerted them more readily to issues about standards. The registered nurse who had the post of Director of Clinical Standards was unpopular with staff and lacked the confidence of the Chair and was replaced. Her successor may have had a disadvantage in coming from a trust which would have offered fewer challenges and greater support. She was able, however, to demonstrate to the Inquiry that she was conscientious and able to work out what needed to done, although she may have found prompt implementation difficult to achieve. The Director of Operations gave an impression of having focused on individual tasks, such as the achieving of targets, at the expense of leading the overall operation of the Trust.

66. The non-executive directors, including the Chair, had an appreciation that there were serious deficiencies in certain areas of the Trust's operation. The Chair provided a list of them to the Inquiry. The other non-executives supported her to set about remedying these by the replacement of the Chief Executive. Likewise, the Director of Nursing who arrived in December 2006 appreciated that there were serious nursing issues to be addressed. In spite of that appreciation, too often the initiation of a process such as the appointment of a new chief executive or the setting up of a new governance structure was regarded as sufficient and the executive could then be left to get on with things. Remedial action has often not been pursued with the vigour and urgency warranted by the situation.

67. The Inquiry examined the clinical floors project and the Board's management of this issue. The Board approved this without an adequate examination of the implications. While placing reliance on the advice of the Executive Director who was the architect of the project, little attention was paid to any other opinion, and little attempt was made to engage front-line staff. There was no adequate impact or risk assessment and, once set in motion, no proactive assessment of how it

was working. Their approach was symptomatic of a passive style from which challenge and engagement with the key issues was absent.

68. With regard to the Board's approach to workforce reduction, this was agreed at a time of maximum financial pressure when there may have been no alternative to staff cuts. However, assurances were too readily accepted as to the safety of the proposals and there was little challenge evident. When the deficiencies were appreciated as a result of the commencement of the skill mix review, this was not progressed with the speed required by the circumstances.

69. The application for Foundation Trust status was pursued by the Board in part as a means of furthering the need for improvement in governance structures rather than ensuring that the Trust was in a genuinely fit state for the application before embarking on it. There may have been external encouragement to seek Foundation Trust status, but it remained the Board's duty to ensure that it was an appropriate step to take. The pressures of the process are likely to have distracted the Board from other tasks. The Inquiry does not accept that the Board set out to deceive anyone with the application, but their declarations in relation to the quality of care provided at the Trust revealed a profound misunderstanding of their responsibilities. The focus seems to have been on processes not outcomes.

70. The Board did not engage with the public as it should have done; in particular, it conducted more business than was appropriate in private. The Board's reaction to the HCC report was individually and collectively one of denial instead of searching self-criticism. The most common reaction among directors was that the report was unfair because it did not adequately reflect the progress that had been made. During the investigation itself, a degree of complacency was shown and there continued to be a lack of urgency in seeking solutions to the problems identified.

71. Although the Chief Executive between January 2005 and March 2009 was not medically fit to attend the Inquiry, documentary material was obtained from which his response to the criticisms of the HCC report could be gleaned, as could the process leading to his departure from the Trust. He asserted that he had been appointed to a failing trust and had achieved a turnaround of the organisation by putting in place a sustainable future, robust governance, and improving quality and standards of care. He considered that the high mortality figures were attributable to coding issues, and that skill mix issues had been identified and were being addressed. Acknowledging that there was work to do, he described the Trust's culture as being inwardly focused and complacent, resistant to change and accepting of poor standards. He considered the HCC report to be unfair. Whatever Mr Yeates may have believed at the time of his departure, in reality the issues raised in this report had not been remedied. He focused on systems, not their outcomes. There was a need for senior management to be deeply involved in service delivery until they could be satisfied that the systems were actually

working. He did successfully get to grips with some issues, but the concerns described by both him and his Chair were largely the same as those discerned by the current Chief Executive on his arrival. This does not suggest a successful period of management.

72. The Chair was asked to leave by the Chair of Monitor on the publication of the HCC report. While such a termination is efficient in the sense that it allows the Trust to move on under new management, it is unsatisfactory that there is no process of accountability which allows for a fair determination of the performance of the individual as against the standards and codes of conduct to be expected of someone in such an important public position.

73. The Chief Executive stepped aside before being formally suspended by the Board which then commissioned an external report into his performance. Although the report recommended that there was a prima facie case for disciplinary action, the Board decided on pragmatic and commercial grounds to negotiate terms for an agreed departure. The result was that the Chief Executive was also forced out of office without any determination of whether his own performance was in breach of any relevant standards or the code of conduct. There was no public accountability of the type that would be expected in the case of, for instance, a doctor.

Mortality statistics

74. The Inquiry has looked at the Hospital Standard Mortality Ratio (HSMR) and the ways in which the hospital death rates are compared with each other. The HSMR for the Trust was significantly higher than the average. It was these figures which attracted the attention of the HCC and caused it to launch its investigation. There are a number of sources for such figures, some of them run as a commercial operation. The methodology and significance of these statistics are subject to academic controversy. Taking account of the range of opinion offered to the Inquiry, including a report from two independent experts, it has been concluded that it would be unsafe to infer from the figures that there was any particular number or range of numbers of avoidable or unnecessary deaths at the Trust. However, there is strong evidence to suggest that these figures mandated a serious investigation of the standards of care being delivered rather than reliance on the contention that they had been caused by coding.

External organisations

75. The Inquiry has received a considerable number of representations that there should be an investigation into the role of external organisations in the oversight of the Trust. Concern is expressed that none of them from the PCT to the Healthcare Commission, or the local oversight and scrutiny committees, detected anything wrong with the Trust's performance until the HCC investigation. While

such an investigation is beyond the scope of this Inquiry, local confidence in the Trust and the NHS is unlikely to be restored without some form of independent scrutiny of the actions and inactions of the various organisations to search for an explanation of why the appalling standards of care were not picked up. It is accepted that a public inquiry would be a way of conducting that investigation, but also accepted that there may be other credible ways of doing so.

Conclusions & Recommendations

76. The deficiencies in staff and governance began before the period under review and were recognised by the management. Any trust where there have been long-term serious organisational challenges will be difficult to turn around. However, the action taken by management to address many of the issues they identified was ineffective. Many of the problems found by the Chair on her arrival in 2004 were still present when the current Chair and Chief Executive took over in 2009.

77. A theme of the evidence about the Board has been reliance on the distinction between strategic and operational issues and a disclaimer of responsibility for the latter. The distinction does not justify directors not interesting themselves in operational matters when it is known that governance systems are either not in place or are untested. There was also a lack of clarity about responsibilities for nursing issues.

78. The Board's approach to some problems such as governance was characterised by a lack of urgency. The issues identified in this report required constant follow-up, review and modification. It was unacceptable that the staff review should have been allowed to take so long to complete and implement.

79. A common response to concerns has been to refer to generic data or benchmarks such as star ratings, rather than the experiences of actual patients. While benchmarks and data-based assessments are important tools, these should not be allowed to detract attention from the needs and experiences of patients. Benchmarks, ratings and status may not always bring to light serious systemic failings.

80. Among other themes the Inquiry has identified from the evidence are:

- a corporate focus on process at the expense of outcomes;
- a failure to listen to those who have received care through proper consideration of their complaints;
- staff disengaged from the process of management;
- insufficient attention to the maintenance of professional standards;

- lack of support for staff through appraisal, supervision and professional development;
- a weak professional voice in management decisions;
- a failure to meet the challenge of the care of the elderly through provision of an adequate professional resource. Some of the treatment of elderly patients could properly be characterised as abuse of vulnerable persons;
- a lack of external and internal transparency;
- false reassurance taken from external assessments; and
- a disregard of the significance of the mortality statistics.

Recommendations

Recommendation 1: The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard.

Recommendation 2: The Secretary of State for Health should consider whether he ought to request that Monitor – under the provisions of the Health Act 2009 – exercise its power of de-authorisation over the Mid Staffordshire NHS Foundation Trust. In the event of his deciding that continuation of foundation trust status is appropriate, the Secretary of State should keep that decision under review.

Recommendation 3: The Trust, together with the Primary Care Trust, should promote the development of links with other NHS trusts and foundation trusts to enhance its ability to deliver up-to-date and high-class standards of service provision and professional leadership.

Recommendation 4: The Trust, in conjunction with the Royal Colleges, the Deanery and the nursing school at Staffordshire University, should review its training programmes for all staff to ensure that high-quality professional training and development is provided at all levels and that high-quality service is recognised and valued.

Recommendation 5: The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.

Recommendation 6: The Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this report and ensure that it:

- provides responses and resolutions to complaints which satisfy complainants;
- ensures that staff are engaged in the process from the investigation of a complaint or an incident to the implementation of any lessons to be learned;
- minimises the risk of deficiencies exposed by the problems recurring; and
- makes available full information on the matters reported, and the action to resolve deficiencies, to the Board, the governors and the public.

Recommendation 7: Trust policies, procedures and practice regarding professional oversight and discipline should be reviewed in the light of the principles described in this report.

Recommendation 8: The Board should give priority to ensuring that any member of staff who raises an honestly held concern about the standard or safety of the provision of services to patients is supported and protected from any adverse consequences, and should foster a culture of openness and insight.

Recommendation 9: In the light of the findings of this report, the Secretary of State and Monitor should review the arrangements for the training, appointment, support and accountability of executive and non-executive directors of NHS trusts and NHS foundation trusts, with a view to creating and enforcing uniform professional standards for such posts by means of standards formulated and overseen by an independent body given powers of disciplinary sanction.

Recommendation 10: The Board should review the management and leadership of the nursing staff to ensure that the principles described in the report are complied with.

Recommendation 11: The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on matters relating to the standard and safety of the service provided to patients.

Recommendation 12: The Trust should review its record-keeping procedures in consultation with the clinical and nursing staff and regularly audit the standards of performance.

Recommendation 13: All wards admitting elderly, acutely ill patients in significant numbers should have multidisciplinary meetings, with consultant medical input, on a weekly basis. The level of specialist elderly care medical input should also be reviewed, and all nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion.

Recommendation 14: The Trust should ensure that its nurses work to a published set of principles, focusing on safe patient care.

Recommendation 15: In view of the uncertainties surrounding the use of comparative mortality statistics in assessing hospital performance and the understanding of the term 'excess' deaths, an independent working group should be set up by the Department of Health to examine and report on the methodologies in use. It should make recommendations as to how such mortality statistics should be collected, analysed and published, both to promote public confidence and understanding of the process, and to assist hospitals to use such statistics as a prompt to examine particular areas of patient care.

Recommendation 16: The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified.

Recommendation 17: The Trust and the Primary Care Trust should consider steps to enhance the rebuilding of public confidence in the Trust.

Recommendation 18: All NHS trusts and foundation trusts responsible for the provisions of hospital services should review their standards, governance and performance in the light of this report.