Care and Compassion in the UK

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Outline

- Background
- Findings Francis Report
- Recommendations/Responses

Background

- In 2009 first inquiry led by Health Care Commission undertaken into Mid Staffordshire NHS Foundation Trust
- Investigation between 2005-2009 all cases that caused concern

  documentary evidence

  consultation key agencies

  300+ individuals interviewed

Background

- One of key recommendations of HCC was:

- *"Department of health should consider investigating 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"*

- In 2010 Robert Francis QC appointed as Inquiry Chairman to lead on a public inquiry. "Francis Report" published in 2013.

"A toxic culture was allowed to develop unchecked which fostered the normalisation of cruelty and the victimisation of those brave enough to speak up" (Robert Francis QC)

Findings….

- Lack of care/dignity/respect:

  - *In the next room you could hear the buzzers sounding. After about 20 minutes you could hear the men shouting for the nurse, "Nurse, nurse", and it just went on and on. And then very often it would be two people calling at the same time and then you would hear them crying, like shouting "Nurse" louder, and then you would hear them just crying, just sobbing, they would just sob and you just presumed that they had had to wet the bed. And then after they would sob, they seemed to then shout again for the nurse and then it would go quiet...*

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

- *‘Just before allowing the relatives to enter the room she discovered a deceased body which had been there for at least 24 hours (possibly 2 days) and at that time none of the staff knew who the deceased was. It took several hours to establish who the deceased patient was and to find all the appropriate paperwork…’*

Findings (cont)

- Numerous warning signs which went unheeded:
  - Cancer Peer Review in 2005; Care of Critically Ill and Critically Injured Children's Peer Review in 2006
  - HCC review of children's services
  - Auditors' reports highlighted risk management system concerns
  - Staff/patient surveys bottom 20% of worst performing trusts
  - Whistleblowing - serious allegations not addressed
  - Royal College of Surgeons 2007 described surgical department as 'dysfunctional'

Headlines from Francis report:

- Culture focused on doing the system's business
- Atmosphere of bullying/fear of adverse repercussions
- No culture of listening to patients
- Inadequate risk assessment of staff reduction/standard of nursing
- Lack of internal and external openness and transparency
- Accountability and responsibility
- Low morale and failure to tackle challenges

- [Mrs Harry – Director of Clinical Nursing] *was very unapproachable, very aloof. She didn't like to be criticised at all. If something was happening that she didn't approve of, didn't like, then your life was made hell. Several of the nursing staff who came to talk to me about their problems they had got with her were saying: I can't do any more because if I do she will just make my life hell.*

  Q:*And that it was a sacking offence not to get that right?*

  A:*Yes. As were lots of other things, as were not achieving the targets, that was a sacking offence.*

  Q:*Is that an environment that makes for a happy ship, do you think?*

  A:*I think it makes it for a very highly pressurised, a highly pressured ship. It is absolutely relentless, around the pressures that people are under in that environment.*

- *I remember at the time when our staffing levels were cut and we were just literally running around. Our ward was known as Beirut from several other wards. I heard it nicknamed that. ITU used to call us Beirut.*

290 recommendations…..

- Overall thousands of pages long with 290 recommendations made:

- Foster a common culture in putting the patient first
- Develop fundamental standards of care
- Ensure openness, transparency and candour
- Make those who provide care properly accountable for what they do
- Enhance recruitment/education/training and support
- Develop and share performance

The aftermath…..

In-depth reviews of care provision/ DH/ NMC

Patients' First and Foremost (2013);

- Preventing problems
- Detecting problems quickly
- Taking action properly
- Ensuring robust accountability
- Ensuring staff are trained and motivated

'Powerful call' to action on tackling individual aspects of NHS culture

Recommendations/forthcoming

- Inspection regime
- Patient focus
- Recruitment/training/leadership “culture of learning”; staff-patient ratios
- Responsibilities, transparency, dissemination
- Strengthen whistleblowing policies/procedures
- New spirit of candour
- Revised NHS constitution (2013)
- DH to reconnect with NHS provision

……apologise to the families of all those who have suffered for the way the system allowed such horrific abuses to go unchecked and unchallenged for so long. On behalf of the government – and indeed our country - I am truly sorry

David Cameron, PM