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Press Statement

Today I publish the report of this Inquiry following my consideration of the evidence of over 250 witnesses and over a million pages of documentary material. It builds on my earlier report, published in February 2010 after the earlier independent inquiry on the failings in the Mid Staffordshire NHS Foundation Trust between 2005 and 2009. I recommend that those seeking a full understanding of all the issues read both reports.

This is a story of appalling and unnecessary suffering of hundreds of people. They were failed by a system which ignored the warning signs and put corporate self interest and cost control ahead of patients and their safety. I have today made 290 recommendations designed to change this culture and make sure that patients come first.

We need a patient centred culture, no tolerance of non compliance with fundamental standards, openness and transparency, candour to patients, strong cultural leadership and caring, compassionate nursing, and useful and accurate information about services.

The evidence at both inquiries disclosed that patients were let down by the Mid Staffordshire NHS Foundation Trust. There was a lack of care, compassion, humanity and leadership. The most basic standards of care were not observed, and fundamental rights to dignity were not respected. Elderly and vulnerable patients were left unwashed, unfed and without fluids. They were deprived of dignity and respect. Some patients had to relieve themselves in their beds when they offered no help to get to the bathroom. Some were left in excrement stained sheets and beds. They had to endure filthy conditions in their wards. There were incidents of callous treatment by ward staff. Patients who could not eat or drink without help did not receive it. Medicines were prescribed but not given. The accident and emergency department as well as some wards had insufficient staff to deliver safe and effective care. Patients were discharged without proper regard for their welfare.

The many experiences like this were truly shocking to hear. Many will find it difficult to believe that all this could occur in an NHS hospital. I want to pay tribute to the many patients and those close to them who bravely and with

great dignity gave evidence to me at the two inquiries. It is their efforts which have brought these shocking facts to light. It is important for them, and all others who have suffered as they have that the necessary changes are made to protect patients and to provide the proper and fundamental standards of care to which we are all entitled.

What brought about this awful state of affairs? The Trust Board was weak. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. It did not tackle the tolerance of poor standards and the disengagement of senior clinical staff from managerial and leadership responsibilities. These failures were in part due to a focus on reaching targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable standards of care.

The purpose of this inquiry was to work out why these problems many of which should have been evident over a period of years, were not discovered earlier. Regrettably there was a failure of the NHS system at every level to detect and take the action patients and the public were entitled to expect.

- The patient voice was not heard or listened to, either by the Trust Board or local organisations which were meant to represent their interests. Complaints were made but often nothing effective was done about them.

- The local medical community did not raise concerns until it was too late.

- Local scrutiny groups were not equipped to understand or represent patient concerns or to challenge reassuring statements issued by the Trust.

- The Primary Care Trusts which were under a duty to arrange for the provision of safe and effective care were not set up for and did not effectively ensure the quality of the health services they were buying; they did not have the tools to do the job properly

- The Strategic Health Authority was the regional representatives of the NHS and the Department of Health. It did not put patient safety and wellbeing at the forefront of its work. It defended trusts rather than holding them to account on behalf of patients. It was uncritical in its support of Foundation trust status for the Trust. It preferred to explain

away concerns such as those about high mortality rates rather than root out matters which would concern any patient.

- Monitor's duty was to ensure that trusts were fit to be granted the independence of Foundation Trust status. It focussed on corporate governance and financial control without properly considering whether there were issues of patient safety and poor care.

- The Department of Health did not ensure that ministers were given the full picture when advising that the Trust's application for Foundation Trust status should be supported. It was remote from the reality of the service at the front line.

- The Healthcare Commission was required to assess trusts against standards which did not adequately test the quality of care being provided to patients, but it was its painstaking investigation by a team of skilled inspectors that eventually brought the truth to light. Even then there was a reluctance by those who had the power to do so to intervene urgently to protect patients.

- Other organisations, including healthcare professional regulators, training and professional representative organisations failed to uncover the lack of professionalism and take action to protect patients.

At every level there was a failure to communicate known concerns adequately to others, and to take sufficient action to protect patients' safety and wellbeing from the risks arising from those concerns. In short the trust that the public should be able to place in the NHS was betrayed.

What caused such a widespread failure of the system? This is not something which can be blamed simplistically on one policy or another, or on failings on the part of one or even a group of individuals. There was an institutional culture in which the business of the system was put ahead of the priority that should have been given to the protection of patients and the maintenance of public trust in the service. It was a culture which too often did not consider properly the impact on patients of actions being taken, and the implications for patients of concerns that were raised. It was a culture which trumpeted successes and said little about failings. Standards and methods of ensuring compliance were not focussed on the effect of service deficiencies on patients There was a tolerance of poor standards and the consequent risk to patients. Agencies frequently failed to share their knowledge with each other.

Assumptions were continually made that important functions were being performed satisfactorily by others. The dangers of the loss of corporate memory from major reorganisations were inadequately addressed and during the reorganisation of PCTs and SHAs there was a loss of focus upon the care patients received.

The NHS is full of dedicated, skilled people committed to providing the best possible care to their patients. There is much to be proud of about what they do for us. However the service so valued in this country and respected internationally is in danger of losing public trust unless all who work in it take personal and collective responsibility to root out poor practice wherever it is to be found.

What do we need?

Conventionally, some might say depressingly, when a disaster has occurred in the NHS the usual approach has been to blame and sack individuals or to propose major reorganisations. What has been found to be wrong here cannot be cured by finding scapegoats, and/ or recommending major reorganisations yet again

What is required now is a real change in culture, a refocusing and recommitment of all who work in the NHS – from top to bottom of the system - on putting the patient first. We need a common patient centred culture which produces at the very least the fundamental standards of care to which we are all entitled, at the same time as celebrating and supporting the provision of excellence in healthcare.

We need common values, shared by all, putting patients and their safety first; we need, a commitment by all to serve and protect patients and to support each other in that endeavour, and to make sure that the many committed and caring professionals in the NHS are empowered to root out any poor practice around them. These values need to be the principal message of the NHS constitution, to which all staff must commit themselves.

How is this to be done?

The NHS is a complex and frequently re-organised system trying to maintain its service against a backdrop of increasing demands and challenging financial expectations. The last thing required is a set of proposals from me requiring more radical reorganisation. So my recommendations are intended above all to support all in the service to make patient centred values and

standards real, but also to bring teeth to the task of changing behaviours where required. Essentially I think five things are needed:

- First, a structure of clearly understood fundamental standards and measures of compliance, accepted and embraced by the public and healthcare professionals, with rigorous and clear means of enforcement: we need a list of standards, about patient safety, the effectiveness of treatment, and basic care - the requirements we will all agree should be in place to permit any hospital service to continue. These standards should be defined by what patients and the public want and are entitled to, and what healthcare professionals agree can be delivered. Non compliance with these fundamental standards cannot be tolerated. Any organisation unable consistently to comply should be prevented from continuing a service which exposes patients to risk. To cause death or serious harm to a patient by non-compliance with fundamental standards should be a criminal offence. Standard procedures, guidance and assessment tools designed to enable organisations and individuals to comply with fundamental standards in different clinical settings should be produced by the National Institute of Clinical Excellence (NICE), with the help of relevant professional and patient organisations. These should include guidance on staffing. Individuals should be supported to report non compliance or matters which might prevent compliance to their organisations. They should be protected when they do this.

  Fundamental standards must be policed by the Care Quality Commission. It is this inquiry's firm conclusion that physical inspection by well qualified, trained and experienced hospital inspectors is the most effective means of monitoring compliance with standards in hospitals. Regulation would also be more effective if compliance with fundamental standards and requirements for clinical and corporate governance and finance control, were regulated by one organisation. The CQC should regulate all these matters together rather than responsibility being divided between CQC and Monitor. The CQC would also be expected to intervene where necessary to protect patients from non-compliance with the fundamental standards.

In all walks of life the buyer wants to ensure that he gets what he pays for. Health should be no different. Therefore commissioners of healthcare services must be required to develop and require compliance with other standards – which I have called enhanced quality standards - of quality, effectiveness and other requirements over and above the fundamental standards. As the buyer of these services on our behalf commissioners must ensure that these enhanced standards are delivered by their providers. In this way the role of the regulator and commissioners responsibility would be simplified and clarified.

- Secondly, openness, transparency and candour throughout the system: A common culture of serving and protecting patients and of rooting out poor practice will not spread throughout the system without insisting on openness, transparency and candour everywhere in it. A duty of candour should be imposed and underpinned by Statute and the deliberate obstruction of this duty should be made a criminal offence.
    - Openness means enabling concerns and complaints to be raised freely and fearlessly, and questions to be answered fully and truthfully;
    - Transparency means making accurate and useful information about performance and outcomes available to staff, patients, the public and regulators.
    - Candour means informing any patient who has or may have been avoidably harmed by a healthcare service of that fact and a remedy offered where appropriate, regardless of whether a complaint has been made or a question asked about it.

Every provider trust must be under an obligation to tell the truth to any patient who has or may have been harmed by their care. It is not in my view sufficient to support this need by a contractual duty in commissioning arrangements. It requires a duty to patients, recognised in statute, to be truthful to them. It requires staff to be obliged by statute to make their employers aware of incidents in which harm has or may have been caused to patients so they can take the necessary action. The deliberate obstruction of the performance of these duties and the deliberate deception of patients in this regard should be criminal offences. So called “gagging clauses” which might prevent a concerned employee or ex employee raising honestly held concerns

about patient safety should be banned. Trusts must be open and honest with regulators. It should be an offence deliberately to give them misleading information. Information provided to the public about performance should be required to be balanced, truthful and not misleading by omission. Quality accounts should be independently audited. The CQC should be responsible for policing these obligations.

- Thirdly, improved support for compassionate caring and committed nursing: proper standards of nursing care lie at the heart of what is required to protect patients when in hospital. The majority of nurses are compassionate, caring and committed. They should be given effective support and recognition, and be empowered to use these qualities to maintain standards. Entrants to the profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of their patients. Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard and their training must incorporate the need to experience hands-on patient care. Named clinicians should be responsible for the welfare and care of each patient in hospital.

  Healthcare support workers are a highly important but insufficiently valued part of the workforce: they provide most of the hands on care for elderly and vulnerable patients. They need the help of consistent training, and standards of performance. Patients are not currently adequately protected from those who are unfit to do this work. The time has come in for healthcare support workers to be regulated by a registration scheme enabling those who should not be entrusted with the care of patients to be prevented from being employed to do so. This needs to be supported by common training standards and a code of conduct. No-one should have hands-on care of patients unless properly trained and registered. Patients and the public are entitled to greater clarity about the status of those who provide direct physical care to them.

  Nursing needs a stronger voice. This can be achieved by strengthening nursing representation in organisational leadership, enhancing the links with their professional regulators, better appraisal, and encouraging strong nursing leadership at ward level. I would like to see more recognition of the extremely important role nursing plays in the care of

older patients by the creation of a new registered status as a registered older person's nurse. I would like their profession to consider how greater authority can be brought to their representative voice.

- Fourthly strong and patient centred healthcare leadership: leadership generally in the NHS is under challenge and needs more effective support. The necessary culture will only flourish if leaders reinforce it every day in every part of the service. A NHS leadership staff college could be created, offering all potential and current leaders the chance to share in a form of common training designed to equip them to exemplify and implement the common culture. They should be supported by a common code of ethics and conduct for all leaders and senior managers.

  The public are entitled to expect leaders to be held to account effectively when they have not applied the core values of the Constitution, or are otherwise shown to be unfit for the role. Currently leaders who are registered as doctors or nurses can be disciplined by a regulator for failing to protect patients. Other leaders cannot. A more level playing field would enhance leadership teamwork and increase the public's confidence in the NHS. It should be possible to disqualify those guilty of serious breach of the code of conduct or otherwise found unfit from eligibility for leadership posts. This will require a registration scheme and a requirement that only fit and proper persons are eligible to be directors of NHS organisations. While this regulatory function could be performed by an existing regulator, the need for a separate entity for this purpose should be kept under review.

- Finally, accurate, useful and relevant information: information is the lifeblood of an open transparent and candid culture. All professionals, individually and collectively, should be obliged to take part in the development, use and publication of more sophisticated measurements of the effectiveness of what they do, and of their compliance with fundamental standards. Patients, the public, employers, commissioners and regulators need access to accurate, comparable and timely information. Improvements are needed in the core information systems for the collection of data about patients, both to support their individual treatment and the accurate collation of information for statistical purposes. Difficulties in achieving this are no

excuse for inaction. The Information Centre for Health and Social Care has an important role to play in this field. Boards must be accountable for the presentation to the public of balanced and candid information about their trusts' compliance with fundamental standards. It should be a criminal offence to be a party to a wilful or reckless false statement as to compliance with safety or fundamental standards.

Many of my recommendations will require development in detail to be implemented. The suffering undergone by patients and those close to them in Stafford demands that the lessons to be learned are not considered for a day or two and then forgotten. Government and the Department of Health have an important role to play in changing the culture, but this does not mean everyone else in the system can sit back and wait to be told what to do. Every single person and organisation within the NHS, and not only those whose actions are described in this report, need to reflect from today on what needs to be done differently in future. All have a responsibility to consider what is exposed by my two inquiries, and to consider how to apply the lessons themselves, individually and collectively. I have recommended that every organisation should report publically on a regular basis on whether they have accepted my recommendations and what they are doing to implement them, and that the House of Commons Health Select Committee should be invited to review regularly the progress being made by organisations which are accountable to Parliament.

My recommendations represent not the end but the beginning of a journey towards a healthier culture in the NHS in which good practice in one place is not considered to be a reason for ignoring poor practice somewhere else; where personal responsibility is not thought to be satisfied by a belief that someone else is taking care of it; where protecting and serving patients is the conscious purpose of everything everyone thinks about day in day out. Patients are entitled to be the first and foremost consideration of the system and all those who work in it. I very much hope that this report and its recommendations will help to bring this about.

6 February 2013