

**MID STAFFORDSHIRE NHS FOUNDATION
TRUST:**

**A review of the procedures for emergency
admissions and treatment, and progress against
the recommendation of the March Healthcare
Commission report**

Professor Sir George Alberti

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INTRODUCTION

In 2007 the Healthcare Commission became aware of a number of apparently high mortality rates for specific conditions and operations at Mid Staffordshire NHS Foundation Trust. This is a small to medium-sized Trust serving a semi-rural population of approximately 300,000. The Healthcare Commission carried out a detailed examination and mortality appeared to be concentrated on those admitted as emergencies. The overall mortality rate had indeed been comparatively high for several years as shown by Dr Foster's Hospital Guide. A comprehensive investigation was therefore carried out between March 2008 and October 2008, focusing on the accident and emergency department, the emergency assessment unit and acute medicine and surgery. During this investigation, early actions were taken as a result of preliminary findings. Evidence was also taken from patients and their families, which indicated major problems.

The independent report from the Healthcare Commission was finally published on March 18th 2009. The main findings were:

- Understaffing of A&E - too few consultants, middle-grade doctors and nurses
- Initial patient assessment by untrained receptionists
- Poor supervision of junior doctors
- Weak leadership of nurses and inadequate nurse training
- Poor equipment in A&E
- Long delays and tendency to move patients to the Emergency Assessment Unit (EAU), Clinical Decision Unit (CDU) and "assess and treat" area in order to meet the 4 hour target before they had been investigated or any diagnosis made
- Lack of protocols and clear pathways
- Chaotic, large, understaffed EAU with little training for the nurses
- Poorly equipped EAU.
- Poor handover from EAU to medical and surgical wards
- Insufficient beds for coronary care or strokes
- Major delays for emergency operations
- Inadequate numbers of experienced surgeons with poor 24/7 cover
- Poor post-operative care
- Very poor patient care on the medical and surgical wards
- Inadequate handling of patient complaints

Many reasons were cited for the poor clinical care. These included: too much focus on finances to the detriment of clinical care; little or no attention to clinical outcomes; inadequate supervision of services by the Trust Board; poor clinical engagement; and, understaffing. In particular, the Trust's application for Foundation Trust status led to major savings being required. This, in turn, led to a major fall in clinical staffing - from an already precarious position. In addition, when the high mortality rate was pointed out to the Trust more attention was paid to questioning the validity of the figures than to the underlying causes and problems. It is also unfortunate that the main PCT commissioning services (South Staffordshire Primary Care Trust) did not pay more attention to standards and quality of clinical care and comments from patients but focused more on throughput and targets.

The Healthcare Commission made a series of recommendations in their March 2009 report. These included:

- A series of actions for the Trust Board, accepting that some actions had already been taken. In particular, that the Board needs to reflect on its arrangements for overseeing the quality and safety of clinical care within the Trust. This includes learning from mistakes, identifying risk, accurate collection of data, acting on the views and experiences of patients, developing more effective clinical audit and clinical engagement.
- Ensuring that recent improvements in the A&E department are sustained and extended.
- Increasing medical and nursing staffing and improving training.
- Increasing emergency theatre sessions.
- Improving access to advice from the critical care team
- A range of measures relating to safety and standards of care.

When the Healthcare Commission report was published, I was asked to undertake a clinical review by the Secretary of State for Health and by Monitor, with the main emphasis on the emergency services encompassing the whole emergency care pathway. I have carried this out from a clinical standpoint with particular emphasis on quality and effectiveness, safety, access, sustainability and patient experience.

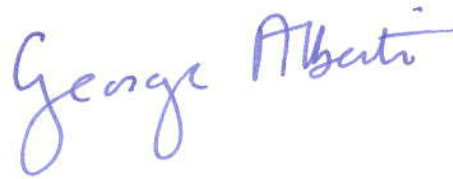
Much has changed to the health context in England in the last two years. There is a renewed focus on safety, patient outcomes and clinical leadership culminating in Professor Lord Darzi's report *High Quality Care For All* published last year. In particular, the principle now that any seriously ill patient should be seen and diagnosed in timely fashion by an experienced clinician and appropriate treatment commenced rapidly has a major impact on planning and delivery of effective services.

My report has been prepared in close collaboration with my fellow clinician, Dr David Colin-Thomé, who has been charged with reviewing the reasons why the Primary Care Trust (PCT), Strategic Health Authority (SHA) did not become aware

of the problems and take action before the Healthcare Commission investigation took place.

My Terms of Reference were:

1. To review the procedures for emergency admissions and treatment at Mid Staffordshire NHS Foundation Trust.
2. To review the Trust's progress against the recommendations made in the Healthcare Commission's report of 17th March 2009.
3. To link closely with and complement the review being undertaken by Dr David Colin-Thomé on practice by the PCT and SHA, and lessons learned by commissioners.



PROFESSOR SIR GEORGE ALBERTI

EXECUTIVE SUMMARY

This review of Mid Staffordshire NHS Foundation Trust was undertaken at the request of the Secretary of State for Health and Monitor following a critical report published by the Healthcare Commission on 19th March 2009. The following were the key observations:

1. There have been major improvements in the A&E department with 4 new consultants, improved nursing skills and prompt, efficient handling of emergency cases, and, improved training of junior doctors. The A&E department is now providing safe, good quality care.
2. There remain problems with the flow of patients through the hospital. Suggestions have been made about improvements in bed management and patient discharge.
3. The principles underlying the operation of the Emergency Assessment Unit are correct but cannot be fully implemented until patient flows improve.
4. There are now 3 acute physicians who have improved greatly the timeliness of care of medical emergencies. The other physicians have agreed to implement a new way of working which will accelerate care and provide early consultant-delivered decisions.
5. There are highly committed, acute surgeons working at the Trust but too few in each of the surgical specialties. A system of networking with neighbouring Trusts is required.
6. Equipment deficiencies were identified by the Healthcare Commission and are still to be rectified by the Trust.
7. The medical wards have too few qualified nurses and every effort should be made to rectify this and to increase numbers beyond those agreed to date. Efforts are also needed to improve nurse training and morale and to refocus attention on the needs of each patient.
8. Care of the elderly should be enhanced at all stages of the patient pathway and a collaborative network should be established with primary and community services with more focus on care of patients closer to home.
9. A similar network or board should be established for urgent and emergency care including all partners, such as the Primary Care Trust (PCT), the ambulance trust, social services, the voluntary sector, pharmacies, patients and the public as well as Mid-Staffordshire Foundation Trust. This could and should greatly facilitate

delivery of care by the most appropriate person in the most appropriate setting in timely fashion.

10. Patients and the public have not been included sufficiently in discussions and decision-making. They should be involved at all levels and more real-time patient and family views should be sought and used to help shape service delivery.
11. The PCT should ensure that quality and safety indicators are built into all commissioning and performance management arrangements.
12. There is an urgent need for a coherent 5-year plan for the Trust with a timed action plan taking into account the changing nature of medicine as outlined in Professor Lord Darzi's report last year. The Trust needs to see clearly where it fits into the overall health economy and should be clear about what it can do well and safely and what should be networked with others e.g. hyper-acute stroke care and some branches of surgery. The plan should be developed together with the PCT and other partners including the public. This will give the public and the staff a clear indication of how the Trust is developing and at what speed and remove much of the current uncertainty and unhappiness.
13. The Trust's staff need to change from a "make-do" culture to a "can-do" culture. There were encouraging signs both at Board level and amongst the staff that this is indeed taking place.

THE REVIEW

I made three visits to the Trust on the 25th March, 7th April and 14th April. I interviewed a wide range of people including managers, clinicians and patients (see Appendix 1). I also visited A&E, the Clinical Decision Unit (CDU), the Emergency Assessment Unit (EAU), the Paediatric Department and Wards 10, 11 and 12 - which were the focus of many patients'/ families' complaints. I also had close conversations with Dr Ian Sturgis who had been asked by the Trust to review their emergency pathways and who visited during the same period. I would like to thank everyone for their frank and open discussions with me and also for providing copies of the Trust's 5-year plan, the Action Plan for 2008-2009 and detailed figures on emergency attendances and admissions.

General comments

I found that much has improved at the Trust since the Healthcare Commission's investigation commenced. Significant numbers of new medical and nursing staff have been employed with obvious benefit. But further appointments are still needed, particularly of nurses. The acting Chair and acting Chief Executive are already having an impact and a new Medical Director, who commenced work on April 15th, has achieved quickly an excellent grasp of what is required to make the necessary improvements. A significant number of the remaining problems, which will be exacerbated by the implementation of the European working time directive, are similar to those found already in many small and medium-sized acute trusts. But this does not mean that they are insoluble. What it does mean is that the Trust has to be absolutely clear about what can and must be done safely and well, what is sustainable and what should be done by or shared with others. The Trust's 5-year plan should reflect this more robustly with a clear understanding of services, which will have to be networked with neighbouring trusts. There is still too much focus on business and finance to the detriment of the real needs of the local population. Safety, quality and day-to-day care of patients could be further improved in some areas. The Trust should pay particular attention to the various recommendations emerging from the National Patient Safety Agency. Significant progress has been made but much remains to be done and is discussed in detail below.

The urgent and emergency care pathway

The urgent and emergency care pathway starts at the point where an individual has a healthcare need - which will become apparent at home or in the community. Many such needs are already met in the community by primary care, social services, pharmacists and the ambulance service. But a large number of people still come or are transported to the local accident and emergency department. Much can be done to offer patients alternative choices for unplanned care thus reducing the need to attend A&E - for example through Urgent Care Centres for less serious illness and injury, through Community Matrons dealing with long term conditions and the elderly and through Rapid Response Teams with clearly defined pathways of care. From my visits to Mid Staffordshire Trust, I could not identify any organisational structure overseeing such developments. I therefore

recommend strongly that an Urgent and Emergency Care Board should be set up involving all partners to plan and review services to meet the urgent and emergency care needs of the population. The new Board should also take responsibility for off site Urgent Care Centres such as those at Cannock Chase hospital and the community hospitals. This would then allow rotation of larger numbers of staff for a wider set of services alongside the introduction of common protocols and quality indicators across all the sites.

There also needs to be clear pathways within the Trust - with the same sense of urgency pertaining throughout the pathway as is now found in the A&E department. An emergency care directorate involving all acute specialties stretching from admission to discharge could help ensure this. I suggest that this should include representatives from all support specialties e.g. radiology, critical care and pathology since the same 24/7 service is needed from them as from the front line clinicians.

Accident and emergency department

This was one of the main areas of concern for the Healthcare Commission. Care was disorganised, there was only one A&E consultant, nurses and junior doctors received inadequate training and equipment was sub-standard.

Overall there were 54000 attendances in 2007-2008 and 49000 in the first 11 months of 2008-2009. Of these 53% were classified as minor and 47% as “intermediate” or major. There are 20 to 30 medical admissions per day of whom the majority are elderly and 10 to 12 surgical admissions of whom only a small number require operation. This excludes children where patients attend the paediatric department directly and which is physically distant from A&E.

Major improvements have occurred and the department is now providing safe, good quality care. An A&E Project Plan is in place and reviewed regularly. The four-hour national access target has been achieved at over 99% since the beginning of February. There are now 4 new A&E consultants (emergency physicians) and 8 middle grade doctors in place. The A&E consultants provide excellent “shop-floor” presence from 8am to 10pm Monday to Friday and noon to 8pm at weekends. In the longer term and to be sustainable there will need to be 2 additional emergency physicians. But I found that the impact has already been considerable. There is also nurse triage every day from 9am to 10pm and 8 Emergency Nurse Practitioners with a matron in charge. There are still, however, fewer nurses than desirable. There is now a strong primary care presence at the front end of A&E from local GPs who deal with minor/ primary care complaints. This operates from 10am to 10pm and is staffed by a rotation of 25 GPs. The A&E consultants have also introduced an accelerated “pit-stop” process for people with major illness. Here they aim to see patients within 30 minutes of arrival and then conduct a 20-minute assessment by an experienced doctor with investigations carried out and a treatment plan established. The consultants have also instituted an immediate review of any patient who dies within 24 hours of emergency admission with obvious benefit in terms of learning. Such mortality reviews should be implemented for ALL patients who die in the hospital. There is excellent collaboration with the acute physicians.

All of this shows major improvements over the past few months. There are still some problems such as the absence of a blood gas meter, and lack of beds to move patients to when admission is needed. There were two CDUs previously and now, quite rightly, there is only one. But questions should be asked about the types of patients being moved into the CDU. Ideally, the unit should be used for patients where extra time is needed before they can go home e.g. mild head injuries, mild overdoses and suspected Deep Vein Thromboses. Occasionally it can be useful if waiting for investigations. However, I found that it was very often used to deal with the overflow of patients when beds were not available elsewhere. The result is that patients are being kept waiting too long, staying for up to 3 days with inadequate nursing cover. The maximum length of stay should be between 12 and 24 hours with the majority shorter than this. This needs to be resolved as a matter of urgency.

I also found a lack of protocols for common conditions. These should be introduced as soon as possible and nurses and junior doctors trained in their use.

Patient satisfaction is assessed regularly. Patient safety and outcomes are of obvious importance. The Trust is using the College of Emergency Medicine's clinical indicators which should promote improvements in performance as well as support benchmarking against equivalent Trusts.

Medical admissions

I found that medical admissions always go via the A&E department to the Emergency Assessment Unit (EAU). Good practice suggests that those patients referred by their GP for medical admission can go direct to the EAU, thus avoiding A&E and speeding the patient's journey through the hospital. However, I found this was not the case at Mid Staffordshire Trust because beds in the EAU are always full. I suggest strongly that this good practice is adopted once bed management has improved (see below). Similarly, I suggest that an emergency assessment service for older people requiring diagnosis and management but not admission should be established on a 5 days per week basis.

Currently, the operation of the EAU is unsatisfactory. This is primarily because there are bed shortages in other parts of the hospital, which means patients stay in the EAU longer than necessary. The EAU should be re-sited closer to A&E. I am told that this is already planned. There are officially 37 beds in the unit but this has been increased to 49. The layout is poor and there are insufficient nurses, particularly to manage the extra number of beds. There remains a shortage of equipment as highlighted in the Healthcare Commission's report, particularly in relation to non-invasive ventilation and cardiac monitoring and this should be addressed urgently.

On the positive side, I found that medical care has improved greatly with the appointment of 3 acute physicians. They provide an excellent daytime service. The other physicians who participate in acute care take over in the late afternoon. However, the practice has been for specialist registrars to look after the acute take patients until the next morning

when the consultant does a post-take ward round. I have suggested a different model of care with much earlier consultant contact following the principle that ill patients deserve to be seen quickly by an experienced consultant. Indeed, the Royal Colleges of Physicians and Surgeons in a joint document stated that medical and surgical emergency patients should be seen by an experienced doctor within 1 hour of referral from A&E. This would greatly enhance the flow of patients and the institution of definitive treatment, and would significantly shorten lengths of stay. The physician and surgeon on call and their specialist registrars should be freed from other duties on their on-take days so that they can see patients immediately if needed. My preferred model is that the physician on duty would start work on the EAU in mid-afternoon overlapping with the acute physician. They would remain on the EAU until 8 to 9 pm when the majority of emergency patients will have reached the EAU. They would then leave a specialist registrar on duty for the night and would do their post-take ward round next morning. I have already discussed this with the on take consultant physicians group who responded favourably.

I found that patients remained longer than necessary on the EAU. There should be a 48 hour time limit with 60% of patients going home from the EAU and others being transferred to the appropriate medical ward. Some beds could be used as a short stay ward for patients requiring slightly longer than 48 hours but not intensive nursing.

I believe that the most serious issue that is contributing to the delays in EAU is the lack of available beds on the medical wards to which patients can be moved. This is not necessarily due to lack of actual beds but due to poor bed management by the Trust (see below).

Medical specialties

I considered these only in relation to medical emergencies. There is a coronary care unit at the Trust but, in my view, more and more coronary patients are likely to move to other hospitals for primary angioplasty. There are however many other cardiac emergencies and the Trust could service its community better by developing a good outreach heart failure service as a priority. There is a good network of cardiologists in the region, which allows step up care as necessary.

There was considerable enthusiasm in the Trust to establish a hyper-acute stroke unit as part of a Staffordshire-wide network. This seems unwarranted. The clinicians said that they see approximately 1 stroke patient per day and, at best, 1 in 10 will be thrombolysed. This requires round the clock CT scanning and, although films can be read remotely, extra resources at the Trust would be required to, amongst other things, ensure 24/7 diagnostics were in place. However, in my view, the priority should be to implement fully the NICE guidelines for head injury and, since resources will be required for this, it makes sense for the Trust to direct its focus here. The Trust can network with another centre - such as Wolverhampton - for hyper-acute stroke care with patients being returned to the Trust after 24 hours for rehabilitation and follow-up. The Trust should,

nonetheless, develop a well-staffed stroke unit for the all important second phase of care with intensive rehabilitation. This could be sited at Cannock Chase.

I found that there is a well developed endoscopy service run between the gastroenterologists and the gastroenterological surgeons.

I found there to be a major need to develop further the services for care of the elderly across the health community. I recommend that a Care of the Elderly Network is set up as soon as possible covering the whole population served by the Trust with representatives from the hospital consultants, social services, the PCT, community services, the voluntary sector, etc. A joint plan should be developed aimed at dealing with as many patients as possible in their home setting. There appeared to be a paucity of Community Matrons who could and should play a key role in home care. A Rapid Response Service could also usefully be developed. In the hospital, care of the elderly services, including social services should see patients as soon as possible after they are admitted to assist in ensuring that they go back to their home/place of residence as quickly as possible. They should (and do) 'pull' patients out of the EAU. They also have a vital role to play in facilitating timely discharge from hospital. With an ageing population, there will be increasing demand for these services and should be an important component of any long term plan for the Trust - as well as for community services.

Emergency surgery

The volume of acute surgical patients admitted to hospital is much smaller than for medicine (10-12 per day) and a minority require operations. Despite this, I found that there are long delays in consultant review of patients and in carrying out operations when these are needed. Part of the problem is due to a lack of available theatres, particularly at weekends. Patients admitted on Friday evening may have to wait until Monday for their operation. There is a particular problem with patients with fractured neck of femur where less than 50% are operated on within 24 hours. Despite this I was impressed by the commitment of the surgeons. Apparently, weekend theatre sessions have now been increased.

The issue is that "general" surgery is now less acceptable as a discipline. Surgery has become much more specialised and constant practice at any operation is required to retain skills and deliver consistently good results. Many surgical specialties have already split away and now run their own rotas, often on the basis of regional or sub-regional networks. Examples include ENT, urology, thoracic surgery and vascular surgery. It is likely that this will happen for the rest of surgery. This creates major problems for small and medium-sized acute Trusts where it is not possible to employ sufficient numbers of each type of surgeon to provide a viable rota, particularly if, as is desirable, a consultant-delivered service is to be organised. Mid-Staffordshire Foundation Trust is one such example. The question is whether the Trust should offer an acute surgical service at all or perhaps a day-time service with one of the other acute Trusts taking patients at night and at weekends. Or perhaps appropriate networks should be established with neighbouring

trusts so that a shared service is delivered. I recommend that further discussions are held urgently with all stakeholders to resolve this issue.

I also found that there has also been an issue with the placement of admitted surgical patients. Patients have in the past been admitted to the EAU but this was found not satisfactory - mainly because different nursing skills are needed. There was a successful, small surgical assessment unit established on a temporary basis but this has now been closed. I suggest that the most satisfactory option, if acute surgery is to be maintained, would be to have a small, discrete unit at one end of one of the surgical wards.

Medical wards (10, 11, 12)

There were particular concerns expressed by the Healthcare Commission about the medical wards. Their report provided many examples of poor patient care and lack of cleanliness. I visited the wards twice and spoke with senior nursing staff, ward staff and patients themselves. My overall impression was of very committed staff rushed off their feet and with little time for a more relaxed approach to patient care. I found the physical layout on the wards unsatisfactory, particularly on ward 10, which is mostly occupied by elderly patients. I spoke with a number of patients and their families and heard no complaints. The wards looked clean.

However, there is a major problem with the numbers of nursing and ancillary staff on the wards. After the financial cuts of two years ago, when staffing numbers were drastically reduced, the agreed complement of staff was increased again. The Trust has significant numbers of vacancies for both nursing and other staff and recruitment is proving difficult. This has been made worse by the adverse publicity received by the Trust. Therefore, the situation is more difficult at present. I found that, even with the increased compliment of staff, there is an imbalance between trained nurses and other staff. The level of patient dependency and acuity in these wards suggests a 60:40 ratio between trained staff and others. A combination of unfilled vacancies and a high level of sickness in reality results in a 50:50 ratio. Ward 10, which has 42 beds, has theoretically 4 trained staff for each shift. This is a bare minimum and should be increased in the near future to 6 per day-time shift. Similarly further increases are needed on each of Wards 10 and 11 from 2 trained nurses to 3 per day-time shift.

I found that there remain issues concerning availability of equipment. The respiratory ward does not have access to non-invasive ventilation. This could and should be rectified. The staff on the wards should make better use of Early Warning Scores, which should be updated at least daily and then acted upon. This would allow an earlier response for patients who are deteriorating. The Trust could usefully adopt the electronic system employed at the Princess Royal Hospital in Telford. I also found that all wards are running at close to 100% bed occupancy with outliers elsewhere in the hospital. This exacerbates greatly many of the problems both on the medical wards and elsewhere in the hospital and should be considered alongside any actions the Trust takes to resolve patient throughput and bed management (see below).

Nursing

There continues to be a major need for improvement with regard to nursing at the Trust. Numbers were barely adequate when the staff cuts occurred in an effort to achieve financial balance. Staffing levels were increased again when the Healthcare Commission began its investigation but not up to the previous numbers. I have already said that recruitment is proving difficult for the Trust but an overall increase in numbers of trained and other ward-based staff must be a major priority for the Trust. Many of the problems I heard about relate directly to bedside care. These stories of patients' experience were not purely related to the distant past. I heard several harrowing patient experiences that had occurred in the last 3 months. My view is that this relates in part to poor staffing numbers. The staff I spoke to (and I did approach a number of ad hoc staff on the wards to hear a wide range of views) were all committed and made clear to me that they wanted to do a good job but did not have the time or perhaps the training to do so. Morale overall was poor. In my view, they have been under pressure for so long that "adequate" care is seen to be good enough. A major effort is needed to change the culture to ensure that staff aim for excellent rather than adequate care and provide the training and the numbers to be able to achieve this aim. In particular, they should be supported to have the time and opportunity for further training and skill enhancement.

Bed management

I found bed management in the Trust to be very poor. Many of the problems concerning the smooth flow of patients through the hospital are due to this. There is plenty of good practice to adopt. There are some straightforward principles that can be applied. I recommend those offered by the Royal Colleges of Physicians and Surgeons - that every patient in the hospital should be reviewed by 11 am to see whether they can be discharged. This should occur on 7 days per week. Full ward rounds are not needed but "board" rounds can suffice. For patients requiring social or other community support after discharge, negotiations with relevant providers should have started when the patient was admitted. If the decision to discharge is made then the patient should go immediately to the discharge lounge where they can receive their medication for home use. This then frees up significant numbers of beds earlier in the day and shortens the length of stay for all concerned. A bed management team should be in place with real time monitoring of bed state to facilitate discharges. All patients should have an Expected Day of Discharge (EDD) noted on the front of their notes and this should be adhered to and updated as necessary. I found this practice was sporadic at present. Ward staff should also have enough time to complete the - at times - copious paperwork, which often accompanies patients. Again, this can be delivered to the patient in the discharge lounge.

Linked to this, the PCT, as a matter of urgency, should ensure that there is sufficient capacity in the community to accommodate patients, particularly in intermediate care. The only patients in the hospital should be those requiring the expertise or facilities of the hospital. My observations were that this is far from the case.

The overall aim must be to have no patient outliers across the hospital, no patients in A&E waiting for a bed and no patients remaining in the EAU for more than 48 hours.

Paediatrics

I visited the paediatric department and met both paediatricians and other members of staff. The intent was to review arrangements for emergency attendances. The department was well laid out with a good atmosphere. Unlike many other Trusts, many emergencies - both minor and major - come direct to the department with only about 35% attending via the A&E department. 40% are referred by their GPs and 25% are brought directly by the ambulance service. There are 5500 to 6000 attendances per year with marked seasonal variation. There are 6 consultants on the rota with specialist registrars and a more junior trainee providing night cover but with consultants often attending at night. There is planned integration with community services in the near future, which will increase the number of consultants on the emergency rota to 8 - which is acceptable. There is always an Advanced Practitioner on duty. The night staff also cover the neonatal department and A&E. Average length of stay for admitted patients is 1½ days. There are good networking arrangements with North Staffs and Birmingham for the more complex cases. The total numbers per day are relatively small but the unit works well and provides a good, safe service with excellent patient and family feedback. There were only 4 complaints last year. In the future, closer union with A&E seems advisable. The new A&E consultants have paediatric training which could provide better integrated care and use of personnel.

Patients

Patients and their care are at the heart of any hospital. It is lack of focus on patients by Mid Staffordshire Foundation Trust, particularly the management which lies at the heart of the problems set out by the Healthcare Commission. Several patients wrote to me to tell me of their poor experiences of care. I met the families of patients who had died at the Trust and who have formed the campaign group *Cure the NHS*. They told me their harrowing stories. I spoke to several patients in the hospital itself. Examples, albeit isolated, of poor patient experience are still occurring. Major changes are needed to ensure that these experiences become fewer and far between. The interim Chair and Chief Executive of the Trust have already made this a top priority. But much needs to be done to achieve this.

Complaints need to be taken seriously and regularly brought to the attention of the Board - and then acted upon. Proactively gathering patient views on a regular basis is very important too. The use of patient questionnaires in all parts of the hospital is one way to do this. The Trust uses hand held electronic devices to gather small samples of patients' experiences and provide real time monitoring of patient opinion. But these require the patient to be competent to answer the questions i.e. this process focuses on the fitter patients on the wards. The Trust needs to consider other approaches to get real feedback from patients and, importantly, their families. I also suggest strongly that one Board

member is tasked to become the patients' champion and that real focus is given to on site professional training to meet patients' needs. There also needs to be a Trust champion on the board representing older people, as suggested some year's ago by the Clinical Director for Older Person's NSF.

The evidence and my own experience show that there is a major problem in communications between the Trust, patients and the public. I suggest that it would be extremely helpful if there were patient/public representatives on all the major Trust committees and sub-committees – whether clinical or managerial. Representatives could come from the Board of Governors, Local Involvement Networks (LINKS), or Patient Advice and Liaison Services (PALS). There should also be regular meetings between the Board and patient/public organisations including the Local Authorities' Overview and Scrutiny Committees. These measures can both help improve real care of patients as well as begin to restore public confidence in the Trust.

Another major element of good, safe patient care is clinical governance. I recommend that this be a major remit of the new medical director whom I met and who already has relevant experience and good ideas. These arrangements should cover all professionals and must be an essential part of any improvement programme. Regular reviews of all deaths in the hospital as well as untoward incidents must be part of this programme and focused on learning rather than blaming.

The role of the Primary Care Trust

I met with members of the PCT on two occasions. I was disappointed that their focus appeared to be more on patient throughput and business than on patient care. They had developed a good long-term strategy for urgent and emergency care but in isolation of other stakeholders and lacking any real specific timed actions. It also appeared to be independent of significant input from the Trust. This document could usefully be re-visited with all partners, including communities and a time bound action plan developed, based firmly on patient needs. Quality and outcomes should be at the heart of their commissioning as promoted through World Class Commissioning. Improved performance monitoring is vital and should be included in their commissioning plans immediately. In developing their plans, the PCT should focus first on the needs of their local population and work closely with the acute trust to decide what can be provided safely and at high quality locally as well as what services are best delivered via clinical networks and a wider range of providers.

Concluding comments

Many improvements have already taken place at the Trust, but much remains to be done. The Trust's Board are aware of this and there is already a change in attitude evident amongst the staff. Overall, there needs to be a swift change from a “**make do**” culture to a “**can do**” culture particularly on the wards. Intimate involvement of the public in the workings of the trust is vital as is total focus on all aspects of patient care. The Board has

already reopened its meetings to the public - which I welcome. Proper involvement of the Board of Governors is important and urgent.

There also needs to be a sense of urgency about patient care. The Trust cannot work properly if speedy, senior decision-making occurs only at the front end of the patient pathway, i.e. in A&E. The same sense must pervade the whole pathway. More staff will be needed and this should be planned now. There must be much closer working between the Trust and the PCT and other community services with the focus fairly and squarely on patients and smooth pathways of care. All organisations involved - the Trust, the PCT, the Strategic Health Authority, Monitor and the Healthcare Commission (now replaced by the Care Quality Commission) - must learn from the obvious problems that have beset Stafford - particularly regarding prompt diagnosis and solutions to problems that emerge.

Overall, the Trust is making progress towards delivering the Healthcare Commission's recommendations set out in their report of March 2009. But much remains to be done. Nonetheless, I am optimistic about the future. The Trust has the potential to become a model small to medium-sized hospital of the future with care delivered promptly and appropriately both in the community and in the hospital - and with poor patient experience a dim and distant memory. This should be reflected in the 5-year plan, which should be developed jointly by the Trust and the PCT with strong public involvement.

RECOMMENDATIONS

- 1) **In the medium term the needs of the local population should be clearly enumerated by the PCT and the Acute Trust and these should be reflected in the 5-year strategy for the Foundation Trust. The focus should be on what can be done safely and well by the Trust and what should be left for other Trusts to do.**
- 2) **An Urgent and Emergency Care Board should be established forthwith to ensure appropriate care and services for all those with an urgent or emergency need. This should be a joint enterprise involving the PCT, Mid Staffordshire Foundation Trust, ambulance trust, patients/public and other relevant partners.**
- 3) **An emergency care directorate should be established in the Trust encompassing all acute specialties with responsibility for the rapid, effective delivery of care from the patient's admission throughout the whole of the patient's care pathway to discharge.**
- 4) **Regular, timely audits should be put in place for all patients who die in hospital.**
- 5) **Two additional emergency physicians (A&E consultants) should be appointed in the medium term.**
- 6) **Protocols for common conditions should be introduced in A&E.**
- 7) **The use and role of the Clinical Decision Unit should be reviewed in the near future.**
- 8) **Equipment deficiencies in the Emergency Admissions Unit and on the medical wards should be reviewed and appropriate purchases made.**
- 9) **The Trust should allow direct admission of suitable patients to the Emergency Admissions Unit, once patient flows have been improved.**
- 10) **A new model of care for medical patients who are admitted should be implemented which provides for much earlier consultant contact.**
- 11) **Lengths of stay on the Emergency Admissions Unit should be limited to 48 hours. The institution of a short-stay ward should be considered.**
- 12) **The Trust should not pursue the development of a hyper-acute stroke service.**

- 13) Care of the elderly services should be enhanced and a care of the elderly network established across primary, secondary and community care.
- 14) The future of acute “general” surgery at the Trust needs careful and urgent consideration.
- 15) There is currently a bare minimum of nursing staff on the main medical wards (wards 10, 11 and 12). This should be increased as soon as possible to 6 trained nurses per day-time shift on ward 10 and 3 on wards 11 and 12 for the day time shifts.
- 16) The complement of nurses in the Trust who provide care to patients in the emergency care pathway should be increased and the training of nurses and other ward workers enhanced.
- 17) Plans should be put in place forthwith to improve bed management with a bed management team and early review of ALL patients in the hospital on a daily (7 days) basis.
- 18) The intermediate care capacity in the community should be reviewed with the PCT and increased if necessary.
- 19) More use should be made of real-time patient questionnaires.
- 20) A member of the Board should be given responsibility as patients’ champion and (s)he or another Board member should have the same role specifically for older people.
- 21) Patient/public representatives should be included on all Board committees and sub-committees
- 22) The PCT should build quality and outcome measures into their commissioning and performance management arrangements with the Trust.
- 23) Clinical governance arrangements should be enhanced with strong Board level support.

Recommendations 19 to 23 are particular pertinent to the review for Monitor.

List of people and groups interviewed

Mid Staffordshire Foundation Trust

David Stone, Acting Chair
Eric Morton, Acting Chief Executive
Dr Manjit Obhrai, new Medical Director
Karen Morrey , Chief Operating Officer
Mike Court, Director Strategy, Planning and Performance
Helen Moss, Director Nursing and Governance
Jill Davies, Deputy Director of Nursing
Nicki Bartlett, Directorate Manager A&E
Jo Perry, EAU Ward Manager
Dr Shaun Nakash, Clinical Lead, Acute Medicine
Dr Chris Turner, Clinical Lead, A&E
Jo Crockett, Practice Development Nurse for Emergency Care
Sue Gallagher, Quality Nurse
Claire McKirdy, Divisional General Manager, Division of Medicine
Dr Cinn, Physician
Dr Oke, Elderly Care Consultant
Dr Jimmy Elizabeth, Lead Consultant, Elderly Care
Dr C Spencer, Physician
Dr S Hearing, Physician
Dr S Hussein, Physician
Mr David Durrans, Acute surgeon
Mr Ishan Bhoora, Acute surgeon
Dr Chris Willard, lead radiologist
Dr Ghosal, Paediatrician
Dr Melville, Paediatrician
Kim Woolliscroft, Head of Paediatrics
Lynn Newell, Primary nurse, Paediatrics.
Angela Grocott, Matron, medical wards
Julie Maddock, senior nurse Cannock Chase, covering on Stafford medical wards
Siew Leach, Nurse Manager, medical wards

PCT

Stuart Poyner, Chief Executive
Geraint Griffiths, Locality Director
Yvonne Sawbridge

Members of the Public

Pat Corfield, Governor of the Trust
Roger Edwards, relative
Julie Bailey and members of *Cure the NHS* group

Others

David Kidney, MP

Bill Cash, MP

Bill Moyes, Monitor

Baroness Young, Care Quality Commission

Heather Wood, Care Quality Commission

Representatives from the Overview and Scrutiny Committees

Dr Ian Sturgess, Consultant

Dr Christine Roffe, Clinical lead for Heart and Stroke Network, Mid Staffs and Shropshire

In addition, I received helpful and relevant information from HM Coroner for Staffordshire South, Mr Andrew A Haigh.