Leading Adult Safeguarding

LESSONS FROM STAFFORD

Robert Francis QC
Three Serjeants’ Inn, London
What inquiry was about ...

To examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner, and appropriate action taken.
Section 59 Vulnerable adults

(1) A person is a vulnerable adult if he has attained the age of 18 and...
(d) he receives any form of health care,
(e) he is detained in lawful custody...
The Safeguarding Vulnerable Groups Act 2006 gives a wide-ranging definition of a vulnerable adult. This includes anyone aged 18 or over who is in receipt of ‘any form of health care.’ This definition is too inclusive to enable appropriate distinctions to be made between the needs or vulnerabilities of adults.
Are they?
concerns were expressed about the lack of compassion and uncaring attitude exhibited by others towards vulnerable patients ... Page 15

[one theme was] 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; [page 25]
Abuse of vulnerable patients

- We entrusted my mother into this hospital to be cared for, to be looked after. But when you think about it, logically, 31st October she was admitted, she died on 6th November and within those few days this hospital let her fall over three times and she had been admitted because she was unstable on her feet. Well, as we thought, immobile. We don’t know she was walking about in the wards until we received incident reports and as I said we were never ever made aware by any of the nursing staff that there was a problem. [Evidence of patient’s son]

- There is no accurate completed incident form relating to your mother’s fall on EAU on 2 November 2008. The three completed incident forms contain misleading and inaccurate information. A review of the nursing and medical records has identified the recording of the three falls which your mother sustained. Unfortunately the entries for the first fall do not give an accurate time of the fall, which in turn are misleading, because the entries span over two consecutive dates. [Reply to complaint]

- This episode indicates serious lapses in the Trust’s duty to care for the safety of an obviously vulnerable patient. [my conclusion]
... I think it is absolutely atrocious that on a ward that deals with elderly people that there is nobody, you know, keeping watch to see the patients who are prone to falls. I mean, there just weren't the staff around and [my mother-in-law] wasn't the only one who was unsteady on her feet. It is diabolical really to think that they can let it happen. You know, maybe you can excuse one but when they know a patient is prone to them, I'm appalled, absolutely...

Ward 10 was an exceptionally large ward in those days. I don't know what it is like today but it was like a crossroads, basically, and the reception desk was in the middle of these crossroads. Nurses – nursing staff were very few and far between when we were there. Ward sisters, there was only about one which we could ever relate to. We could never find them.
I think that is fine as long as it isn’t dependent upon [this], because there are a lot of people who do not have relatives who are fit and able to go in and so what happens to them? You see, the most vulnerable are going to be the ones who, because they have little support or they don’t have relatives who can go in and help, what happens? I mean, we helped others in the ward, didn’t we, while we were there. We were going round and we were taking lids off drinks and we were helping to put things in reach.

Evidence of a family asked to help feed their elderly relative – 1st report page 90
The daughter of a patient in ward 11

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...
The daughter-in-law of a 96 year old patient

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.
A patient death
Systemic failure of safety?

A detailed investigation has been undertaken including obtaining information from 14 members of staff and considering a substantial number of documents. The following problems have been identified:

- failure to control diabetes
- failure to administer prescribed drugs
- failure to undertake nursing handovers properly or at all
- failure to complete nursing records adequately or at all
- failure to conduct medical ward rounds properly
- failure to make adequate or proper notes of ward rounds and care plans
- failure to give the patient a diabetic menu
- failure to report this matter as a SUI in a timely fashion
- failure to report to the Coroner

Extract from Trust investigation report

©2013  Robert Francis QC
It would appear that there were several systemic failures and issues which caused the SUI to occur in this particular case. Unfortunately, it cannot be said that these failures are an isolated incident and unlikely to re-occur. It is clear from talking to the staff (and examining other medical records) that similar issues are occurring regularly.
Case 5

126. The patient was admitted to EAU on 27 May 2005 following a fall at home. The family visited on 29 May 2005 to find extensive bruising to the patient’s forehead, right-hand side of the head and a cut to the right eye. The family believed that the patient had fallen but there were no incident forms to determine whether or not a fall had occurred in the EAU or if the injuries related to the fall at home. The action plan in response, on 22 January 2007 (following referral of the complaint to the HCC), stated that upon admittance to the EAU all patients would be assessed for risk of falls and that all staff would be trained in a new falls policy (which included notifying relatives when a fall occurred).

Case 6

127. The patient was admitted to the EAU on 19 January 2007 and family attended on 20 January 2007 to be informed that patient had fallen out of bed and hit his head. The complaint was made on 9 July 2007 and response was completed on 10 February 2008, including a statement in the action plan saying that all staff in the EAU would be instructed to maintain effective communication after a patient had fallen.

Case 7

128. The patient had fallen out of bed in the EAU and the family had not been informed. A complaint was made on 4 September 2007 and the response was completed on 8 October 2007, including an action plan that stated staff were to inform relatives when falls had occurred, should complete an incident report and utilise FRASE.
Warning signs

- Patient stories
- Mortality
- Complaints
- Staff concerns
- Whistleblowers
- Governance issues
- Finance
- Staff reductions
Some of them were so stroppy that you felt that if you did complain, that they could be spiteful to my Mum or they could ignore her a bit more.

There would have been a lot of little incidents that just made you feel uncomfortable and made us feel that we didn’t want to approach the staff. I did feel intimidated a lot of the time just by certain ones.

you have rushed the blood through, I said to the sister, and she said, ... I have had to come in and give the blood and don’t moan... because I have had no break today. That’s what she said, and she probably hadn’t had a break. So I didn’t mention the frusemide to her because she was obviously fraught.

I think he felt as though he didn’t want to be a nuisance. Because of their attitude in the beginning when he first mentioned about the epidural, he felt as though it was a waste of time of saying that he was in pain.
I mean in some ways I feel ashamed because I have worked there and I can tell you that I have done my best, and sometimes you go home and you are really upset because you can’t say that you have done anything to help. You feel like you have not – although you have answered buzzers, you have provided the medical care but it never seemed to be enough. There was not enough staff to deal with the type of patient that you needed to deal with, to provide everything that a patient would need. You were doing – you were just skimming the surface and that is not how I was trained.

A nurse
The nurses were so under-resourced they were working extra hours, they were desperately moving from place to place to try to give adequate care to patients. If you are in that environment for long enough, what happens is you become immune to the sound of pain. You either become immune to the sound of pain or you walk away. You cannot feel people’s pain, you cannot continue to want to do the best you possibly can when the system says no to you, you can’t do the best you can.

A doctor who started in A&E in October 2007
Perhaps I should have been more forceful in my statements, but I was getting to the stage where I was less involved and I was heading to retirement ... I did not have a managerial role and therefore I did not see myself as someone who needed to get involved. Perhaps my conscience may have made me raise concerns if I had been in a management role, but I took the path of least resistance. In addition ... most of my patients were day cases and there was less impact on those patients. There were also veiled threats at the time, that I should not rock the boat at my stage in life because, for example, I needed discretionary points or to be put forward for clinical excellence awards.

Evidence given to the Public Inquiry
A negative culture?

PRESSURE
Targets
Finance
FT status
Jobs

HABITUATION
Tolerance
Denial
External reassurance
Someone else’s problem

REACTION
Fear
Low morale
Isolation
Disengagement
No openness

BEHAVIOUR
Uncaring
Unwelcoming
Bullying
Keeping head down

©2013 Robert Francis QC
The system’s business not the patients

- GPs
  - Did not look for concerns or pass them on
- Patient and public groups
  - Inward looking
  - Insufficient support or expertise
- Scrutiny committees
  - Did not listen
- PCTs
  - Not equipped to fulfil theoretical duty re quality
- SHAs
  - Did not react to potential safety implications
- DH
  - Insufficient attention to safety implications of reorganisation and targets
  - Insufficient information to minister on concerns about the Trust

©2013 Robert Francis QC
Recommendations

- Common values
- Fundamental standards
- Openness, transparency and candour
- Compassionate, caring, committed nursing
- Strong patient centred healthcare leadership
- Accurate, useful and relevant information
- Culture change not dependent on Government
Values – clarity and commitment

- Put patients first
  - Staff put patients before themselves
  - Staff do everything in their power to protect patients from avoidable harm
  - Openness and honesty with patients regardless of consequences for themselves
  - Direct patients to where assistance can be provided
  - Apply NHS values in all their work
- Make NHS Constitution the shared reference point for values
- All NHS and contractors to commit to NHS values
Fundamental standards

- What the public see as absolutely essential
- What the professions accept can be achieved
- Enshrined in regulation by Government
- Compliance measured by evidence-based methods
- Policed by CQC [including governance required to meet these standards]
- Distinguish from enhanced quality standards subject to commissioning
Prescribed medication given
Food and water to sustain life and well being supplied and any needed help given
Patients and equipment kept clean
Assistance where required provided to go to the lavatory
Consent for treatment obtained
Fundamental standards
Sanctions

- **Persistent failure** – stop/close the service
- **Death or serious harm caused by breach** - **criminal liability** for individuals and organisations, unless not reasonably practicable to comply
  - Defence for individual to have reported obstacles to compliance
  - Prosecution matter of last resort/serious cases
- **Isolated incidents**: no tolerance: investigate reasons and correct.
NICE to provide evidence based guidance and procedures which will *enable compliance* with fundamental standards in each clinical setting.

NICE also to provide evidence based *means of measuring* compliance.

Guidance to include measures for *staff numbers and skills* in each clinical setting required to enable compliance with fundamental standards.
Openness, transparency & candour

- **Openness**: enabling concerns and complaints to be raised freely and fearlessly, and questions to be answered fully and truthfully
- **Transparency**: making accurate and useful information about performance and outcomes available to staff, patients, public and regulators
- **Candour**: informing patients where they have or may have been avoidably harmed by healthcare service whether or not asked
Candour

- **Statutory obligation**
  - Individual professionals under a duty to inform the organisation or relevant incidents
  - Healthcare provider organisations under a duty to inform patient

- **Statutory sanction**
  - Wilful obstruction of these duties should be a criminal offence
  - Deliberate deception of patients in performing duty should be a criminal offence

- No censoring of critical internal reports and full information for patients

- Remedy for patients for non-performance of duty of candour
Openness

- Welcome complaints and concerns
- Gagging clauses to be banned
- Independent investigation of serious cases
- Involving complainants, staff
- Real feedback
- Real consideration by Trust Board
- Information on actual cases shared with commissioners, regulators, and public
- Swift and effective action and remedies
Transparency

- Honesty about information for public
- Balanced information in quality accounts about failures as well as successes
- Independent audit of quality accounts
- Criminal offence of reckless or wilful false statements by Boards re compliance with fundamental standards
- Truth not half truths to be told to regulators
- Criminal offence to give deliberately misleading information to regulators
- CQC to police information obligations including information on enhanced quality standards
ACCURATE USEFUL RELEVANT INFORMATION

- Individual and collective responsibility to devise performance measures [R262-267]
- Patient, public, commissioners and regulators access to effective comparative performance information for all clinical activity
- Improve core information systems
LESSONS FROM STAFFORD

Robert Francis QC
Three Serjeants’ Inn, London