

PRIORITISING PATIENT SAFETY¹

This case study is provided as a cautionary tale to board members. It demonstrates the importance of ensuring that service quality and patient safety are at the heart of the organisation's strategy and are not secondary to other objectives. It points to the role of the Board in ensuring that organisational systems reflect this commitment to patient safety and service quality. Significantly, it identifies the risks for NHS boards that remain insulated from processes of engagement that would allow them to triangulate board performance reports with the reality of staff concerns and the patient experience of care.

Mid Staffordshire NHS Foundation Trust

In 2007, the Healthcare Commission (HCC) noted that Mid Staffordshire NHS Foundation Trust (MSNHS) had had an above average mortality rate for a range of conditions and treatments for some years. MSNHS was unable to provide a suitable explanation for these rates, in-keeping with a longstanding history of poor information provision. HCC concluded, on investigation, that there were deficiencies in almost all components of emergency care at MSNHS. HCC identified issues of insufficient staffing (following several years of reductions from a level that was already recognised as low in 2002) and facilities, leading to inappropriate assessment, delays in treatment and inconsistent approaches to important procedures, as well as understaffed and 'chaotic' wards.

Despite the Board's claims to the contrary, MSNHS's objectives appear to have focused insufficiently on service quality and patient safety: national targets, including financial balance, and a drive to gain Foundation Trust (FT) status, took priority. This analysis was evidenced by analysis of Board minutes, the Board placing financial performance ahead of addressing staff shortages, and further supported by the views of nursing and medical staff.

In the years preceding investigation, the Board experienced significant changes in executive leadership, with changes in CEO, medical and nursing directors. The Board overall demonstrated little openness, with many discussions held away from the public, public meetings reducing from monthly to quarterly and the governance and risk committee reporting to the Board in private. NEDs reported difficulties in challenging the executive in public; and that they felt insufficiently informed to challenge on issues of

¹ Healthcare Commission. Investigation into Mid Staffordshire NHS Foundation Trust. London: Healthcare Commission, 2009.

patient care, limiting the extent to which strategies that were potentially damaging to safety – such as staffing – could be debated.

The HCC investigation identified governance of clinical risk as weak: mortality meetings were ineffective; identification of and learning from serious untoward incidents was inadequate, with the trust risk register populated insufficiently. The clinical audit system was not responsive to concerns highlighted in outcome data, tended not to follow up on identified changes, and had under-resourced leadership; and there was little engagement in national audits. Complaints about numerous ward failings – such as dignity, hygiene, documentation and administration of medicines – were not communicated effectively to the Board (information to the Board reduced in 2005 with the closing of a committee chaired by a NED that reviewed patient complaints); and there was no evidence that clinical risks placed on the corporate risk register were discussed at Board level. Overall, HCC concluded that the Board was ‘insulated from the reality of poor care’; this is reflected in the Board’s reluctance to attribute disturbing outcomes to inadequate care, preferring instead to focus on clinical coding as an explanation. This ‘insulated’ culture was naturally at a disadvantage in the event of making important decisions in the event of an impending crisis.

While MSNHS made significant efforts to communicate with the public, these were directed towards ‘selling’ MSNHS in support of its drive for FT status, rather than to learn from public need and patient experiences; and managerial decisions on processes of care failed to take account of patients’ opinions. Such matters as mortality data and a *C. difficile* outbreak were not disclosed to the public. This approach is likely to have reduced the quality of information provided to the organisation and reductions in public trust once MSNHS’s poor approach to safety was made a matter of record.

Board members claimed to have made much effort in engaging with staff. However nursing and medical personnel reported feeling unsupported, with management imposing their decisions from above, with little consideration of clinicians’ views or concerns regarding safety. This disregard firstly reduced the quality of decision making in the MSNHS; but this was compounded by clinicians’ disengagement from governance processes, further reducing the potential for identifying and learning from events and responding appropriately.