

Investigation

# Investigation into Mid Staffordshire NHS Foundation Trust

March 2009



## Summary report

# Summary

The Healthcare Commission carried out this investigation into apparently high mortality rates in patients admitted as emergencies to Mid Staffordshire NHS Foundation Trust since April 2005, and the care provided to these patients. It also considered the trust's arrangements for monitoring mortality rates and its systems for ensuring that patients were cared for safely.

Our particular focus was on emergency admissions. We looked at the pathway of care for patients admitted as emergencies: the accident and emergency (A&E) department, the emergency assessment unit, and the surgical and medical elements of emergency admissions.

The investigation was carried out between March 2008 and October 2008. Staff from the Healthcare Commission worked with a team of external expert advisers. The membership is listed in appendix B. We interviewed over 300 people, including almost 100 patients admitted as emergencies or their relatives, past and present staff at the trust, and staff at other organisations. We reviewed the case notes of more than 30 patients who were admitted as emergencies and subsequently died. We examined over 1,000 documents including policies, reports, audits and records of meetings.

## Synopsis of events leading to our decision to investigate

During the summer and autumn of 2007, the Healthcare Commission became aware, through its programme of analysis of mortality in England, of a number of apparently high mortality rates for specific conditions or operations at the trust.

In our work on mortality, we recognise that some 'alerts' (that is, indications that patients

may be exposed to greater than expected risk) can be due to errors in the data or to insufficient adjustment for other factors, so a team of analysts assesses each case to establish whether there are sufficient concerns to follow up with a trust. If we do follow up an alert, we will initially ask a trust to provide further information. In many cases, this is enough to satisfy us that no further action is needed. We can escalate a case if concerns about the safety of patients have not been adequately addressed, or we think these have not been properly recognised by the trust.

In this investigation, further analysis showed that the trust consistently had a high mortality rate for patients admitted as emergencies, which it could not explain.

The rate had been comparatively high for several years, but the trust had not investigated this. In April 2007, Dr Foster's Hospital Guide showed that the trust had a hospital standardised mortality ratio (HSMR) of 127 for 2005/06, in other words more deaths than expected. The trust established a group to look into mortality, but put much of its effort into attempting to establish whether the high rate was a consequence of poor recording of clinical information.

The response of the trust to our requests for information contained insufficient detail to support its claim that the alerts were due to problems with its recording of data, and not problems with the quality of care for patients. This response, and the concerns from local people about the quality of care, led the Commission to decide that a full investigation was required.

Our key findings are summarised below and set out in full in the body of the report.

## The views of patients and relatives at the trust

When we announced the investigation, we had an unprecedented response. In all, 103 patients and relatives contacted us. Of these, 99 were critical of, or had had a poor experience at, the trust. The main areas of concern they raised were A&E, the emergency assessment unit and medical wards 10, 11 and 12. Concerns were also expressed about some surgical wards. A major concern expressed by patients and relatives related to poor standards of nursing care.

Although we recognise that this was not a statistically representative sample of patients and relatives, their concerns reinforced what we found through observations, reviews of case notes, complaints and interviews – disorganisation, delays in assessment and pain relief, poor recording of important bodily functions, symptoms and requests for help ignored, and poor communication with patients and families.

In the Healthcare Commission's 2007 survey of inpatients (the latest national survey available), the trust was in the worst 20% for 39 out of 62 questions. This was a poor result. The trust was in the worst 20% for overall standards of care and whether patients felt that they were treated with respect and dignity in the hospital.

## Mortality rates at the trust

Through our programme to analyse mortality rates in England, we received an unprecedented 11 alerts about high mortality at the trust, four of these after the investigation was launched. Six came from the Dr Foster Research Unit at Imperial College, London, as part of its analysis of data, and five from the Commission's own internal surveillance of data from all trusts. Details of the alerts are set out in appendix E.

The alerts at the trust were wide-ranging and suggested a general problem with regard to mortality. We considered data across the trust, which showed that mortality was high as regards emergency admissions, but not for elective admissions.

Our analysis focused on patients aged 18 and over who were admitted as emergencies. The results were 'standardised' (that is, made comparable with each other by taking account of various factors) for a number of factors, including age, sex and the type of condition that they had when admitted to the hospital. Since April 2003, the trust's standardised mortality ratio (SMR) had been consistently higher than expected. If outcomes were the same as would be expected when compared with similar trusts, the SMR would be 100. For the three years from 2005/06 to 2007/08, the trust's SMR for patients admitted as emergencies aged 18 and over varied between 127 and 145.

Looking at the three financial years covered by the investigation, we conducted a statistical analysis of the SMRs to examine to what extent they could have been due to random variation. We concluded that, for the three years we examined, there was a less than 5% probability that the high mortality rates at the trust for patients admitted as emergencies aged 18 or over were due to chance.

Standardised mortality was found to be high across a range of conditions including those involving the heart, blood vessels, nervous system, lungs, blood and infectious diseases. Our full investigation, including visits to the trust, examination of documents and wide-ranging interviews, has led us to conclude that there were systemic problems across the trust's system of emergency care.

## The trust's arrangements for the collection, reporting and use of clinical information

The trust had a long history of poor information about its services. The accuracy of coding of information (that is, the system for cataloguing types of surgical and other interventions) had been poor, but had improved since 2007. The log of activity in theatres had been badly maintained and it was not possible to match information between systems, such as the theatre log and the national Hospital Episode Statistics data. Individual patients' data could not be tracked or linked in these different systems.

Although Dr Foster's analysis showed that the trust had the fourth highest hospital standardised mortality ratio (HSMR) in England for the three-year period 2003-2006, the trust only began to monitor clinical outcomes after the publication of the high rate by Dr Foster in 2007. The trust established a group to consider mortality, but considered that poor coding was the likely explanation for the high rate.

We found that, when challenged, neither the trust nor individual consultants could produce an accurate record of their clinical activity or outcomes for patients. This meant that we could not analyse the volume of surgical work and its outcomes.

## Management of patients requiring emergency care

### A&E and the emergency assessment unit

The detailed evidence for these findings is outlined in the section in this report on the A&E department and the emergency assessment unit (EAU). It came from a wide range of sources including interviews with staff, relatives and patients, observations, reviews of case notes, complaints, trust documents and external reports.

When we visited the A&E department in May 2008, the initial evidence raised serious concerns. We held an urgent meeting with the chief executive and followed this immediately with a formal letter requiring urgent action.

The trust did not have clear protocols and pathways for the management of patients admitted as emergencies. The A&E department was understaffed and poorly equipped. There were too few nurses to carry out an immediate assessment of patients. This was left to the receptionists, who had no clinical training. The patients in the waiting room could not be seen from the reception area. The department lacked essential equipment, such as sufficient defibrillators for every resuscitation trolley.

The nurses in A&E had not had enough training and development, and leadership had been weak. Patients often waited for medication, pain

relief and wound dressings. There were delays in scanning patients out of normal hours. The most senior surgical doctor in the hospital after 9pm was often junior and inexperienced.

There were too few consultants to provide on-call cover all day, every day. There were too few middle grade doctors. The junior doctors were not adequately supervised, and were often put under pressure to make decisions quickly in order to avoid breaches of the target for all patients to be seen and moved from A&E in four hours. For the same reason, patients were sometimes rushed from A&E to the EAU without proper assessment and diagnosis, or they were moved to the 'assess and treat' area, even though staff were not formally allocated to the area and patients were not properly monitored there.

The EAU was large, with a poor layout, making it difficult for nurses to see patients. It was busy and frequently chaotic. It was understaffed, and communication was often poor between nurses and patients, and nurses and doctors.

During 2007/08, the nurses had little in-service training. Not all the nursing staff had the correct skills to observe and care for the variety of patients admitted as surgical and medical emergencies. On the bays with cardiac monitors, the nurses had not been trained to read the monitors. On occasions, the equipment was turned off.

Observations of patients were not carried out as they should have been and poor records were kept of patients' intake and output of fluids and food. Patients sometimes received incorrect medication or did not get their correct medication in a timely manner, if at all. There was poor compliance with generally accepted standards of practice in the control of infection.

### Patients admitted as medical emergencies

The detailed evidence for these findings is outlined in the section on medical admissions. It included interviews with staff, relatives and patients, observations, complaints, trust documents, national surveys and external reports.

For patients admitted to the medical wards, there was sometimes poor communication with, and handover from, the EAU. Care was reported to be good for patients with heart attacks on the acute coronary unit, although there were problems with the cardiac monitors. However, because of lack of beds on the coronary unit, some patients with heart attacks remained in the EAU and were nursed in a non-specialist area.

The reconfiguration of the medical beds on floor two and associated changes in nursing staff had led to the creation of clinical areas that were poorly managed and understaffed.

The care of patients was unacceptable. For example, patients and relatives told us that when patients rang the call bell because they were in pain or needed to go to the toilet, it was often not answered, or not answered in time. Families claimed that tablets or nutritional supplements were not given on time, if at all, and doses of medication were missed. Some relatives claimed that patients were left, sometimes for hours, in wet or soiled sheets, putting them at increased risk of infection and pressure sores. Wards, bathrooms and commodes were not always clean.

Nurses often failed to conduct observations and identify that the condition of a patient was deteriorating, or they did not do anything about the results.

There was only one bay, with four beds, for patients with acute stroke. This was insufficient for the number of patients. There was no facility on the respiratory ward for non-invasive ventilation. There had been a number of problems with arrangements for resuscitation, including some serious incidents involving the contents of resuscitation trolleys. The bleep system for the management of cardiac arrests did not work effectively on several occasions. Mobile phones had to be used as a contingency.

### **Patients admitted as surgical emergencies**

The detailed evidence for these findings is outlined in the section on patients admitted in

an emergency with surgical problems or traumatic injuries. It included interviews with staff, relatives and patients, observations, reviews of case notes and inquest summaries, trust documents and external reports.

Many doctors and nurses working in surgery considered that staff on the EAU and on medical wards did not have the right training and skills to look after surgical patients.

The general surgeons did not work well together and there were few agreed protocols in surgery. This meant that patients needing emergency operations out of normal hours might receive different care and a different operation to that received from 9am to 5pm, Monday to Friday.

There were not enough doctors on duty out of hours, and the most senior surgical doctor after 9pm at night could be quite inexperienced.

In line with local understanding, the ambulance service took most, but not all, patients with severe or multiple trauma to other hospitals with specialised trauma services. For this reason, there was no trauma team at the trust. However, some staff were concerned that nurses on the EAU did not have the right training to look after those patients with traumatic injuries (such as broken limbs) who were admitted to the trust. In addition, the unit did not have equipment for traction or specialist hoists. We noted that, at times, there were too few staff to open a sufficient number of critical care beds.

For patients requiring emergency surgery, there was only one list for theatre at weekends. There was no system to assign priority to cases. Often emergency caesarean sections or surgical operations (such as removing an appendix) would take priority. This meant that patients with a broken hip might have to wait from Friday to Monday or Tuesday to have their operation. This inappropriate management meant that, for several days, these patients would not be allowed to eat or drink for many hours. On some occasions, patients who were designated as 'nil by mouth' were also inadvertently not given their essential medication.



From our review of case notes, from inquests and from findings from the alerts that the Healthcare Commission received on mortality, we noted a number of cases where patients had developed clots in the deep veins of their legs or pelvis and died from these clots breaking off and blocking the blood flow to their lungs. The trust did not have effective arrangements to prevent this or comply with accepted national guidance.

The care of post-operative patients was poor, such that signs of deterioration were missed or ignored until a late stage. When things went wrong, the trust was poor at recognising errors, reporting serious incidents and learning lessons.

### Review of case notes

The Healthcare Commission reviewed the case notes of 30 patients who had died. Our case reviews were undertaken on a small scale, but nevertheless threw significant light on the arrangements for clinical quality and governance prevailing in the trust. We found that, in many of the cases, at least one element of the clinical management or monitoring of their condition was unsatisfactory. Areas of concern included infrequent reviews of patients by doctors, the lack of systematic monitoring of whether the patients were recovering or deteriorating, and the failure to respond adequately to signs of deterioration. There was inadequate monitoring to identify common complications of surgery.

### What were the reasons for the failings at the trust?

It is the view of the Healthcare Commission that there were deficiencies at virtually every stage of the pathway of emergency care. This can be illustrated by following the patient's pathway.

When patients arrived in A&E, they were usually assessed by reception staff with no clinical training, before waiting in an area out of sight of the staff in reception. There was no regular check by nursing staff of the patients

in the waiting room. Some essential equipment, such as cardiac monitors, was missing or not working. Assessment and treatment were often delayed.

There were too few doctors and nurses, alongside poor training and supervision, and junior doctors were put under pressure to make decisions quickly without advice and support from more senior doctors. Doctors were moved from treating seriously ill patients to deal with those with more minor ailments, in order to avoid breaching the four-hour waiting time target. Patients were moved to the clinical decision unit to 'stop the clock' but were then not properly monitored, since this area was not staffed. Patients had to wait for medication, pain relief, wound dressings and antibiotics. There was only a relatively junior doctor available after 9pm to give advice on surgical patients. There was no specialist trauma team. In summary, the care and assessment of patients fell well below acceptable standards.

Sometimes patients were rushed to the emergency assessment unit (EAU) without proper assessment or discussion, and without appropriate specialist care. The EAU was a large ward with a poor layout. It was busy, noisy and sometimes chaotic with too few nurses. Many of the nurses did not understand the cardiac monitors and did not always carry out observations adequately to identify whether a patient's condition was deteriorating. There were many instances of patients not receiving the medication they needed.

There were too few beds for patients who had had a stroke, not all patients with heart attacks went to the acute coronary unit, there was no non-invasive ventilation on the respiratory ward, and critical care beds were not always available. The medical wards on floor two were seriously understaffed and there were grave concerns about the standards of nursing care.

There were too few theatre sessions at weekends and consequent delay in getting to theatre, especially for trauma patients, and some patients did not get essential

medication. Post-operative complications were not always recognised.

Surgical practice was idiosyncratic, relationships were poor and there was little multidisciplinary team work. There were concerns about the level of cover by medical staff at night and at weekends.

Across the trust, there were shortcomings in resuscitation and arrangements to avoid potentially fatal blood clots were inconsistent. There was a shortage of critical care beds and concern about access to medical advice from critical care specialists.

It is our view that all these factors would have contributed to a poor outcome for patients.

### **The trust's approach to its mortality rate**

One of the aims of the investigation was to clarify how the trust investigated its apparently high mortality rates.

The trust assured us that its mortality outcomes group undertook reviews of samples of case notes of patients who had died in hospital during particular periods. This was to ascertain whether the deaths were expected (unavoidable) and whether there were any questions arising about the quality of care provided to the patients.

Our scrutiny of their information, however, found that the reviews had not been sufficiently objective or robust. Moreover, the case notes revealed some sub-standard practice, which should have been identified and learned from.

### **Arrangements for governance and risk**

The chief executive inherited a structure of governance that did not function effectively. Since 2005, there had been considerable change in the structure and responsibilities relating to governance and the management of risk.

The trust's system for identifying serious untoward incidents was poor, with failures to report some incidents and opportunities to learn lessons missed. Other incidents that were

reported by staff consistently highlighted problems relating to the levels of staff, poor care for patients, and poor handovers when patients were moved from one ward to another. Many of these issues required consideration and resolution at a strategic level, but were rarely considered by the board or by its governance and risk sub-committees. There was no systematic mechanism to follow up any actions required or to share lessons.

The medical and surgical divisions failed to resolve problems such as 'nil by mouth', cardiac monitors, the cardiac bleep system, portable suction, and preventing blood clots and pulmonary embolism. Often these problems were listed on the corresponding risk register, but little effective action had been taken.

There were many complaints from patients and relatives about the quality of nursing care. These primarily related to patients not being fed, call bells not being answered, patients left in soiled bedding, medication not being administered, charts not being completed, poor hygiene and general disregard for privacy and dignity. Worryingly, the trust's board appeared to be largely unaware of these. In the reports seen by the board, these complaints were grouped into, and effectively lost in, categories such as "communication" or "quality of care".

The trust reported it had made efforts to engage clinical staff, but many senior doctors whom we spoke to considered that the trust was driven by financial considerations and did not listen to their views. They gave credit for the trust having a clear direction, but said that inflexible ways of imposing change had left many feeling marginalised.

Although most non-clinical staff thought that care at the trust was good, the majority of doctors we interviewed would not have been happy for a relative to be treated at the trust. In a 2006 survey, only 27% of staff said they would be happy to be cared for at the trust, compared with 42% nationally.

The trust generally performed poorly on clinical audit. There was no one taking the lead for clinical audit for a year and the trust-

wide group did not meet at all during this period. When audits were carried out, there was no robust mechanism to ensure that changes were implemented. When re-audits were required, they were often not undertaken, even if they had been recommended by a Royal College. The trust did not participate in many of the national audits run by the specialist societies.

The trust did not have an open culture where concerns were welcomed. Overall, the system that was intended to bring clinical risk to the attention of the board did not function effectively, and the board appeared to be insulated from the reality of poor care for emergency patients.

### The trust's board and outcomes for patients

The board stated that the care of patients had always been a priority. However, no information on clinical outcomes went to the board until the publication by Dr Foster of the hospital standardised mortality ratio (HSMR) in April 2007. Even then, it went only to the private part of the meeting.

No annual report on the control of infection went to the board until July 2007, and that only went to the private part of the meeting.

The routine reports on performance that went to the board were at so high a level that they did not identify the failings in care of patients. The information on complaints and incidents was often incomplete, or so summarised that it left non-executives at a disadvantage in being able to perform their role to scrutinise and challenge on issues relating to the care of patients.

### Informing the public

The trust's board preferred to discuss matters in private, even those that were not confidential or commercially sensitive. It did not discuss the Dr Foster HSMR or the alerts from the Healthcare Commission in public.

An outbreak of *Clostridium difficile* (*C. difficile*) occurred in the spring of 2006, and rates

continued to be high during that year, but the trust did not report or acknowledge in public that it had an outbreak.

### The actions of the trust's board

The year 2006/07 was a challenging one for the NHS, as trusts were required to achieve financial stability. That year, the trust set itself a challenging agenda to meet national targets for cost improvement, stabilise its finances, and become an NHS foundation trust. The trust set a target of saving £10 million, including a planned surplus of £1 million. This equated to about 8% of turnover. To achieve this, over 150 posts were lost. Although the stated intention was to minimise the loss of clinical staff, the number of nurses was significantly reduced. This was in a trust that already had comparatively low levels of staff (see pages 90-93 for details) and at a time when nurses felt they were poorly supported as a profession.

The combination of the reorganisation of wards, the reduction of beds (more than 100 fewer beds between 2005 and 2008, 18% of the total) and the loss of staff meant that the care of patients was further compromised. Areas with longstanding problems, such as A&E, were not given sufficient attention by managers.

The board claimed that its top priority was the safety of patients. However, even though clinical problems were well known, and the trust declared a financial surplus in 2006/07, it did not seek to redress the staffing problem it had exacerbated by reducing the number of nurses. The evidence suggests that the top priority for the trust was the achievement of foundation trust status. The failure of the trust to resolve the problems in A&E and to invest in staff is not consistent with the trust doing its reasonable best to provide a safe and effective service for patients.

The fact that the organisation concentrated mainly on clinical coding as the explanation for poor outcomes suggests that there was a reluctance to acknowledge, or even consider, that the care of patients was poor.



It was clear from the minutes of the trust's board that it became focused on promoting itself as an organisation, with considerable attention given to marketing and public relations. It lost sight of its responsibilities to deliver acceptable standards of care to all patients admitted to its facilities. It failed to pay sufficient regard to clinical leadership and to the experience and sensibilities of patients and their families.

### **Developments since the investigation was announced**

It is, of course, impossible to determine what actions would have been taken by the trust if there had not been an investigation. The agreement at the end of March 2008 to fund the deficit in the numbers of nurses was taken after the board knew there was going to be an investigation.

Since January 2008, there has been a net gain of 46 qualified nurses and 51 healthcare support workers. The trust has increased the number of matrons from three to 12. However, in November 2008, the trust's board noted that further recruitment had been stopped because of actual and anticipated financial pressures, although the trust was 40 nurses below the previously agreed establishment. The trust, though, has told us that the board has not stopped recruitment and will, as part of the 2009/10 business plan, revisit the review of the establishment and take a view on recruiting to the outstanding posts.

When we expressed concerns to the trust, it welcomed them, responded positively and began to take action. The trust received formal notification of our concerns about the A&E department on 23 May 2008. It immediately set up a steering group for emergency care. Significant progress has been made, but there is still a need for further improvement. Two new consultants have been appointed, but the original consultant went on long-term sick leave. The middle grade rota is now fully staffed and there is a programme of training for junior and middle grade doctors. The number of nurses increased, but many of the

new staff were inexperienced and there was still only one band seven nurse. A new model of care was introduced in the autumn of 2008. Triage is in place for 12 hours a day.

Ward-based training on the use of modified early warning scores (MEWS) was introduced in the autumn of 2008. A training package was also agreed to ensure that staff were competent to use cardiac monitors. A four-bedded surgical assessment unit was opened. Two additional beds were opened on the trauma ward. The trust is reviewing the provision of emergency theatre lists at weekends. Additional sessions have been arranged at short notice when necessary.

The mortality group has become the clinical outcomes group and is chaired by the chief executive. The trust reports that it is taking action in order to ensure that changes happen following complaints. Early signs are that mortality for emergency admissions is lower than previously, although the definitive figures for 2008 are not available yet.

The trust deserves credit for the improvement in the prevention and control of infection and it was recently found to comply with the hygiene code.

### **Overall conclusion about the trust**

This was a small trust trying to support a range of specialties. It had become a foundation trust and improved its finances. However, it did not have a grip on operational and organisational issues, with no effective system for the admission and management of patients admitted as emergencies. Nor did it have a system to monitor outcomes for patients, so it failed to identify high mortality rates among patients admitted as emergencies. This was a serious failing.

When the high rate was drawn to the attention of the trust, it mainly looked to problems with data as an explanation, rather than considering problems in the care provided. The trust's board and senior leaders did not develop an open, learning culture, inform themselves sufficiently about the quality of

care, or appear willing to challenge themselves in the light of adverse information.

The clinical management of many patients admitted as emergencies fell short of an acceptable standard in at least one aspect of basic care. Some patients, who might have been expected to make a full recovery from their condition at the time of admission, did not have their condition adequately diagnosed or treated. As late as September 2008, we found unacceptable examples of assessment and management of patients. The trust was poor at identifying and investigating such incidents.

In the trust's drive to become a foundation trust, it appears to have lost sight of its real priorities. The trust was galvanised into radical action by the imperative to save money and did not properly consider the effect of reductions in staff on the quality of care. It took a decision to significantly reduce staff without adequately assessing the consequences. Its strategic focus was on financial and business matters at a time when the quality of care of its patients admitted as emergencies was well below acceptable standards.

The trust deserves credit for progress on infection control and for responding positively to the concerns of the Healthcare Commission.

### **The role of external organisations**

Although South Staffordshire Primary Care Trust (PCT) commissioned services from the trust, it was initially distracted by the organisational change following the merger that created the PCT in 2006, and then focused on the number of patients treated and the cost. They had few measures of the quality of care or outcomes at the trust, and relied in part on external measures such as the Healthcare Commission's annual health check. Once the concerns of a campaign group were drawn to their attention, the PCT took action to address the individual concerns of patients and relatives, and to investigate and help to improve the quality of care at the trust.

West Midlands Strategic Health Authority (SHA) had also been created in 2006 through a merger and it too suffered from the accompanying loss of organisational memory. There was nothing to alert the SHA to concerns about the quality of care until the publication by the Dr Foster unit of the high hospital standardised mortality ratio in the spring of 2007. The SHA was reassured by the trust that it was investigating mortality appropriately.

We thought that information from the coroner would be useful for the investigation. We were disappointed that he declined to provide us with any information about the number or nature of inquests involving the trust.

### **The national picture and lessons for other organisations**

A number of the findings of this investigation in respect of acute hospital care are potentially relevant to the whole NHS. These include the need for:

- Trusts to be able to get access to timely and reliable information on comparative mortality and other outcomes, and for trusts to conduct objective and robust reviews of mortality rates and individual cases, rather than assuming errors in data.
- Trusts to identify when the quality of care provided to patients admitted as emergencies falls below acceptable standards and to ensure that a focus on elective work and targets is not to the detriment of emergency admissions. Care must be provided to an acceptable standard 24 hours a day, seven days a week.
- Trusts to ensure that a preoccupation with finances and strategic objectives does not cause insufficient focus on the quality of patients' care.
- Trusts to ensure that systems for governance that appear to be persuasive on paper actually work in practice, and information presented to boards on performance (including complaints and incidents) is not so

summarised that it fails to convey the experience of patients or enable non-executives to scrutinise and challenge on issues relating to patients' care.

- Senior clinical staff to be personally involved in the management of vulnerable patients and in the training of junior members of staff, who manage so much of the hour-by-hour care of patients.
- Trusts to identify and resolve shortcomings in the quality of nursing care relating to hygiene, provision of medication, nutrition and hydration, use of equipment, and compassion, empathy and communication.
- Good handovers when reorganisations and mergers occur in the NHS.
- PCTs to ensure that they have effective mechanisms to find out about the experience of patients and the quality of care in the services that they commission.

## Recommendations

In this report, we have drawn together the different strands of numerous, wide-ranging and serious findings about the trust which, when brought together, we consider amount to significant failings in the provision of emergency healthcare and in the leadership and management of the trust.

We have therefore written to Monitor, the regulator of NHS foundation trusts, in accordance with the Health and Social Care (Community Health and Standards) Act 2003 (s53(6)), to highlight these significant failings. We had previously raised concerns with Monitor about the leadership of the trust, and we note that both the chairman and chief executive have left the trust in the two weeks leading up to the publication of this report.

Irrespective of the above, we expect the trust to consider all aspects of this report, including all our findings, which detail serious failings at different levels and across different parts of the trust's services. Here, we highlight where action is particularly important.

## Action by the board

The trust's board must ensure that there is a systematic means of monitoring rates of mortality and other outcomes for patients. This information should inform the board's discussions about the quality of services at the trust, and also inform action taken to improve outcomes for patients.

More generally, the trust's board needs to reflect on its arrangements for overseeing the quality and safety of clinical care within the trust. In particular, how the trust:

- Develops and promotes an open, learning culture.
- Collects and reports information accurately, both internally and externally, and in sufficient detail.
- Identifies and mitigates risks to the safety of its patients.
- Identifies correctly, and then reports, investigates adequately and learns from serious incidents and unexpected deaths.
- Learns from, and ensures that necessary improvements are made following incidents, near misses and complaints.
- Engages clinicians and develops effective clinical audit.
- Considers and acts on the views and experiences of patients who use the trust's services.

## A&E department

Recent improvements to the emergency department – confirmed by a recent unannounced visit we made to the trust – must be sustained and extended to ensure that the service is safe, that it meets the needs of patients, and that the department is adequately staffed and equipped at all times.

## Staffing and capacity

The trust must continue the work it has started to recruit additional nursing and medical staff, to ensure that care provided to patients throughout the trust, including at night and at weekends, is safe and keeps to accepted standards.

The trust needs to review the training and supervision of its nursing staff and junior doctors, to ensure that they are undertaking appropriate roles, are confident and clear about the expectations placed on them, and are receiving all necessary support.

The trust must ensure adequate availability of theatre sessions to ensure that it is able to handle demand in an emergency without delay, and has an effective means of determining which cases requiring emergency surgery should receive priority.

The trust must ensure that there is adequate access for clinical staff to advice and support from medical staff in the critical care (intensive care) service, and ensure this is independent of the availability of beds in the critical care unit.

## Standards of care

The trust must ensure that its medical and nursing staff deliver basic aspects of care, such as reviewing patients on a regular basis, monitoring their condition, and identifying and managing any complications that may arise. The trust must ensure that there is timely review of patients by senior doctors.

In the light of specific findings in this report, the trust needs to audit its arrangements for and, where appropriate, equipment used in relation to: medication (particularly on admission and for patients who are 'nil by mouth'); the resuscitation of patients; non-invasive ventilation; cardiac monitoring; and anticoagulation.

## National recommendations

Analysis undertaken in this and other trusts shows worrying variations across the NHS in

the quality of coding of clinical outcomes, and variations in the extent to which statistical information is used to monitor the quality of local services and inform decisions at a senior level within NHS trusts.

This is of concern in a modern, information-driven health service where the interpretation and use of data is a fundamental means of improving clinical care. We recommend formally that all NHS trust boards have access to comparative data on outcomes for patients, including mortality, that is accurate, complete and as up-to-date as possible.

While recognising the challenges in ensuring that mortality rates are accurate and expressed in a way that does not cause unnecessary alarm among patients, or lead to unhelpfully risk-averse behaviour among clinicians, we believe that mortality rates can be published in a meaningful way to help patients to make informed choices about the quality of clinical care.

Boards of NHS trusts need to be focused at all times on the safety and quality of the services provided to patients. This includes having information available to boards that properly captures the experience of patients, so that non-executives can scrutinise and challenge the care received by patients.

The NHS and appropriate professional and educational bodies need to examine why the experience of patients on general wards in trusts that we have investigated continues to be of a poor standard, and take urgent action to improve the quality of nursing care in these areas.

PCTs need to develop more effective mechanisms to learn about the quality of care, the actual experience of patients and the outcomes of care in services that they commission, and give more priority to this aspect of commissioning.

The NHS needs to ensure effective handovers when reorganisations and mergers occur, so that information on services is transferred effectively to the new organisation.

If you would like this information in other formats or languages, please telephone 0845 601 3012.

### Albanian

Ky botim gjendet në gjuhë dhe formate të tjera. Ju lutemi telefononi në 0845 601 3012.

### Arabic

هذه الإستمارة متاحة بلغات وبأشكال أخرى عند الطلب  
نرجو الاتصال على الرقم 0845 601 3012.

### French

Cette publication est disponible dans d'autres formats et d'autres langues. Merci d'appeler le 0845 601 3012.

### Gujarati

આ પ્રકાશન બીજા પ્રકારો અને ભાષાઓમાં વિનંતી  
પર મળશે. કૃપા કરીને આ નંબર 0845 601 3012  
પર ફોન કરશો.

### Kurdish

ئهم بڵاوکراوهیه به شیوه و زمانهکانی تر دابین کراوه.  
تکایه تلهفون بکه بو ژماره تلهفونی 0845 601 3012.

### Pashto

دغه خپرونه په نورو بنو او ژبو کې هم ترلاسه کېږي.  
هیله ده چې 0845 601 3012 لمبرته تیلیفون وکړئ.

### Polish

Niniejsze wydanie jest dostępne na prośbę  
w innych formatach i językach. Proszę  
dzwonić pod numer telefonu 0845 601 3012.

### Punjabi

ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਮੰਗ ਕਰਨ 'ਤੇ ਦੂਜੀਆਂ ਫਾਰਮੈਟਾਂ ਅਤੇ ਜ਼ਬਾਨਾਂ ਵਿੱਚ  
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### Serbian

Ova publikacija je dostupna i u drugim  
formatima i jezicima. Molimo Vas pozovite  
0845 601 3012.

### Somali

Daabacaaddan waxaa lagu heli karaa qaabab  
iyo luuqado kale. Fadlan soo dir taleefoonka  
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### Spanish

Esta información se encuentra también  
disponible en otras lenguas y formatos.  
Llame al: +44 (0) 845 601 3012.

### Sylheti

এই তথ্যপত্রটি অন্ধ এবং বধির লোকদের পড়ার ও বোঝার  
উপযুক্ত নমুনায় এবং অন্যান্য ভাষায় পাওয়া যায়।  
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### Traditional Chinese

這份刊物提供有其他格式和要求的語言版本。  
請致電 0845 601 3012。

### Urdu

یہ پبلی کیشن طلب کرنے پر دیگر زبانوں اور وضع میں دستیاب ہے۔  
براہ کرم 0845 601 3012 پر ٹیلی فون کریں۔

### Vietnamese

Ấn bản này được cung cấp ở những định dạng  
khác và bằng ngôn ngữ khác theo yêu cầu.  
Hãy gọi điện tới số 0845 601 3012.

### Yoruba

A ti ṣe iwé yi ni oríṣíríṣí èdà ati ède míràn.  
È kàn si wa lori 0845 601 3012.



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