The Mid Staffordshire NHS Foundation Trust Inquiry

Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust: January 2005 - March 2009
Chaired by Robert Francis QC

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Final Report Of The Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust Published

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The final report into the care provided by Mid Staffordshire NHS Foundation Trust was published today. The Inquiry Chairman, Robert Francis QC, concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care.

Robert Francis QC has made 18 recommendations for both the Trust and Government. His final report is based on evidence from over 900 patients and families who contacted the Inquiry with their views.

The evidence gathered by the Inquiry shows clearly that for many patients the most basic elements of care were neglected. Calls for help to use the bathroom were ignored and patients were left lying in soiled sheeting and sitting on commodes for hours, often feeling ashamed and afraid. Patients were left unwashed, at times for up to a month. Food and drinks were left out of the reach of patients and many were forced to rely on family members for help with feeding. Staff failed to make basic observations and pain relief was provided late or in some cases not at all. Patients were too often discharged before it was appropriate, only to have to be re-admitted shortly afterwards. The standards of hygiene were at times awful, with families forced to remove used bandages and dressings from public areas and clean toilets themselves for fear of catching infections.

Speaking at the publication of his final report, Robert Francis QC said:

"I heard so many stories of shocking care. These patients were not simply numbers they were husbands, wives, sons, daughters, fathers, mothers, grandparents. They were people who entered Stafford Hospital and rightly expected to be well cared for and treated. Instead, many suffered horrific experiences that will haunt them and their loved ones for the rest of their lives."

The Inquiry found that a chronic shortage of staff, particularly nursing staff, was largely responsible for the substandard care. Morale at the Trust was low, and while many staff did their best in difficult circumstances, others showed a disturbing lack of compassion towards their patients. Staff who spoke out felt ignored and there is strong evidence that many were deterred from doing so through fear and bullying.

Robert Francis QC added:

"It is now clear that some staff did express concern about the standard of care being provided to patients. The tragedy was that they were ignored and worse still others were discouraged from speaking out."

The Inquiry concluded that a number of the deficiencies at the Trust had existed for a long time. Whilst the executive and non-executive Board members recognised the problems, the action taken by the board was inadequate and lacked an appropriate sense of urgency.

The Trust's board was found to be disconnected from what was actually happening in the hospital and chose to rely on apparently favourable performance reports by outside bodies

such as the Healthcare Commission, rather than effective internal assessment and feedback from staff and patients. The Trust failed to listen to patients' concerns, the Board did not review the substance of complaints and incident reports were not given the necessary attention.

Problems at the Trust were exacerbated at the end of 2006/07 when it was required to make a £10 million saving. The Board decided this saving could only be achieved through cutting staffing levels, which were already insufficient. The evidence shows that the Board's focus on financial savings was a factor leading it to reconfigure its wards in an essentially experimental and untested scheme, whilst continuing to ignore the concerns of staff.

Announcing the Inquiry findings, Mr Francis told staff and patients:

"A number of staff and managers at the hospital, rather than reflecting on their role and responsibility, have attempted to minimise the significance of the Healthcare Commission's findings. The evidence gathered by this Inquiry means there can no longer be any excuses for denying the scale of failure. If anything, it is greater than has been revealed to date. The deficiencies at the Trust were systemic, deep-rooted and too fundamental to brush off as isolated incidents."

The Inquiry concluded that it would be unsafe to put a figure on the number of avoidable or unnecessary deaths at the Trust. Robert Francis QC has recommended, given the lack of understanding surrounding mortality statistics and their use, that the Department of Health set up an independent working group to urgently review the gathering and use of mortality data in the NHS.

Over the course of the Inquiry, many people expressed alarm at the apparent failure of external organisations to detect any problems with the Trust's performance. Robert Francis QC has recommended that the Department of Health commission an independent examination of these bodies in order to restore public confidence in the system.

Despite the findings of the Inquiry, Robert Francis QC has concluded that Stafford Hospital should not be closed. He believes that whilst there is still much work required at the Trust, the new Executive team has made a successful start in improving the safety and quality of care it provides. To assist the Trust in this process 15 recommendations for the Trust have been made and he has recommended that the Secretary of State for Health reviews the Trust's status as a Foundation Trust.

Speaking in Stafford Mr Francis said:

"I have been struck by the commitment of the local community to its hospital. So many people who gave evidence were motivated because they care deeply about the hospital and want to see it improve. I hope that the Trust will soon be able to regain the confidence of its local community which it will achieve, not through words, but demonstrable actions and results."

The presentation of his report was concluded with a message for all concerned with the management of NHS hospital services that:

"People must always come before numbers. Individual patients and their treatment are what really matters. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences. This is what must be remembered by all those who design and implement policy for the NHS."