A matter of trust

Governance failings at an NHS Foundation Trust have been blamed for poor patient care by the Healthcare Commission amid allegations that the body put its strategy before the quality of its services. Neil Hodge reports

FOR A hospital trust, achieving foundation status is an important and impressive achievement. With more managerial and financial freedom, those hospitals that gain such status have greater independence from the Department of Health and are freer to respond more directly to the particular needs of local patients, thereby ensuring better quality healthcare. Or at least that is how it is supposed to work.

For one hospital, however, its aspirations to achieve foundation trust status resulted in severe staff shortages, low morale, an ill-equipped accidents and emergency department, delays in treatment, poor infection controls, and unacceptable patient care – all of which contributed to it having one of the highest patient death rates in the country. The hospital's board had prioritised financial management and strong budgeting over effective care, and patients paid the price for that decision.

That hospital was Mid Staffordshire NHS Foundation Trust. In March this year the Healthcare Commission, which regulated the National Health Service (NHS) – it has since been superseded by the Care Quality commission – issued a damning report into the governance failings of the organisation.

Following a six month investigation, the commission found that the hospital "did not have a grip on operational and organisational issues" and showed "deficiencies at virtually every stage of the pathway of emergency care." While the board claimed that its top priority was the safety of patients, the commission says "the evidence suggests that the top priority for the trust was the achievement of foundation trust status".

Governance deficit

Two weeks before the commission published its report, Monitor, the independent regulator of NHS foundation trusts, used its formal powers to appoint interim replacements after chief executive Martin Yeates and chairman Toni Brisby both stepped down. In a letter to Yeates dated 23 May 2008 – just three months after the trust received foundation status – Dr Heather Wood, investigation manager at the Healthcare Commission, wrote that "there appears to be an almost complete lack of effective governance" at the hospital.

Yet these problems in governance can be detected as far back as December 2002. Then, the Healthcare Commission's predecessor, the Commission for Health Improvement, published a clinical governance review of the trust. It noted several areas that needed improvement. It said that the low number of nurses was a cause for concern, that the quality of clinical data was poor, and that the hospital should develop an open and learning culture. When the »

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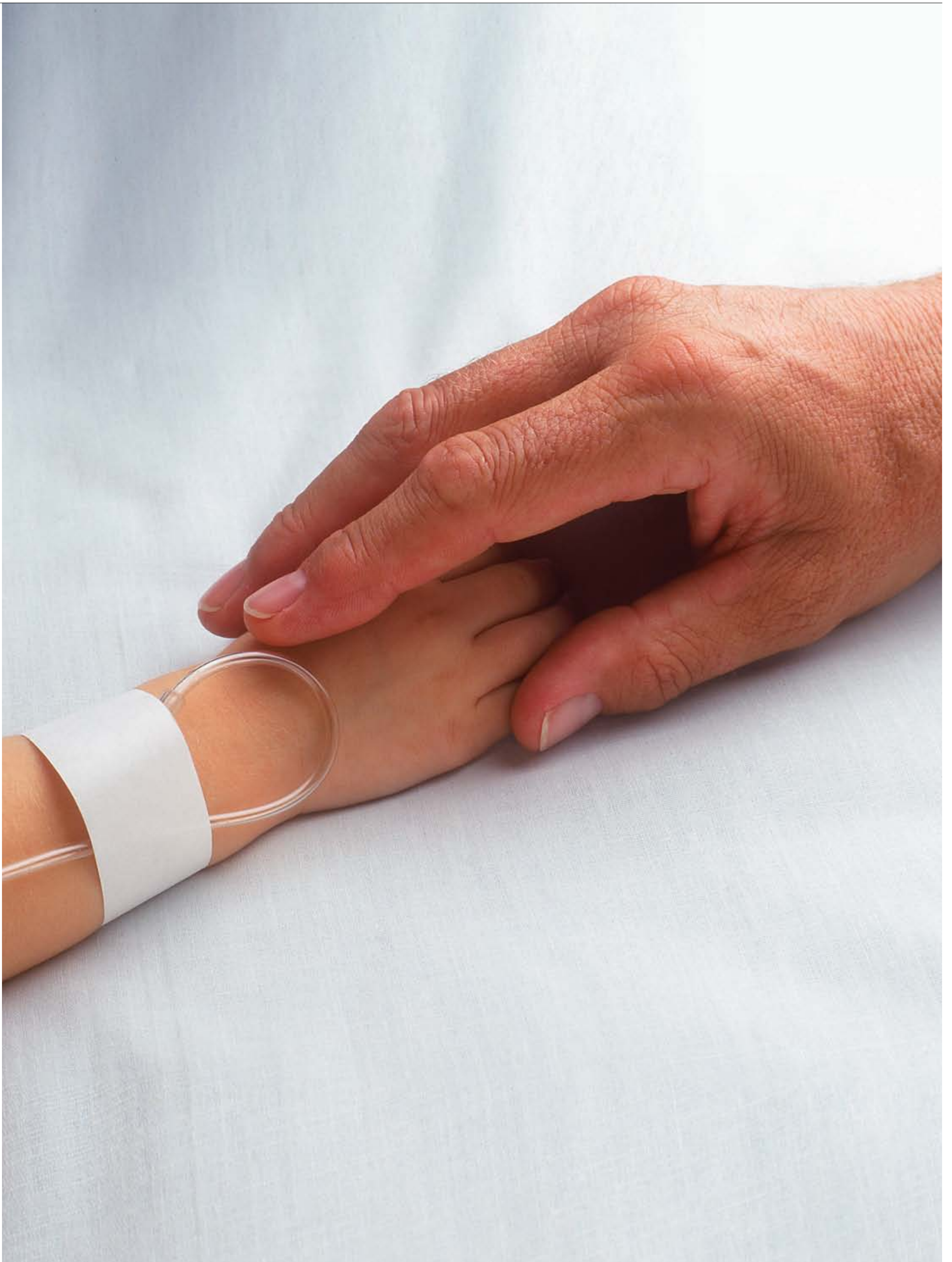

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» commission reported again on the trust in March 2009, it found that the same areas were still areas of concern.

While the commission notes that Yeates had "inherited a structure of governance that did not function effectively", a spate of organisational and senior management changes also impacted on corporate governance. During the first 18 months after he was appointed as chief executive in August 2005, a number of structures and posts were changed. These included the appointment of a director of nursing, a chief operating officer and clinical heads of divisions. All members of the executive team were changed, with the exception of the director of finance who retired in 2008. The supporting structures for the executive team were also revised. As a result, the number of management changes may have contributed to the board failing to recognise the seriousness of the failings in clinical care and complaint handling.

As well as internal pressures on governance, financial stability became a major issue in 2006-2007 when the government set strict budget targets on all NHS trusts. Like many hospitals, the trust set itself a challenging agenda to meet national targets for cost improvement, stabilise its finances, and become an NHS foundation trust. It set itself a target of saving £10m, including a planned surplus of £1m (about 8% of turnover). But it decided to achieve this by cutting over 150 posts, even though the hospital was comparatively under-staffed – as the 2002 report had noted. Even when the trust achieved a surplus, it did not recruit staff to help in the areas of its clinical practice that were failing, such as accident and emergency.

Financial focus

Due to the increased focus on financial management, clinical care and information gathering suffered. In fact, clinical audit and record-keeping

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became so bad that, according to the healthcare information provider partly funded by the NHS called Dr Foster, the trust had no idea that it had the fourth highest hospital standardised mortality ratio (HSMR) in England for the three-year period 2003-2006. The ratio is a key statistical measure to monitor how many patients with particular conditions die, compared with how many would be expected to die. A value over 100 indicates higher than expected mortality. Mid Staffordshire had a rating of 125.

The commission report says that it was not until April 2007 that a head of clinical audit was appointed, which meant that no one took responsibility for the role for a year and there was no management-level discussion of the issue. Until then, the only clinical audit in A&E was undertaken by doctors in training. Even 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, such as the Royal College of Physicians. Such colleges are the professional membership bodies of medical staff and their recommendations on clinical practice carry a great deal of weight, though not all of the recommendations they make have to be carried out by the hospital. A number of senior clinical staff described the clinical audit planning process as poor or patchy. Some were unsure how it was meant to work and one non-executive director described the plan presented to the board two years ago as "a mess".

The commission also found that information gathering and communication were not areas in which the trust excelled. In its report, it wrote that the trust had a long history of providing poor information about its services. The log of activity in theatres had been badly maintained and it was not possible to match information between systems, which meant that individual patients' data could not be tracked or linked. Furthermore, when challenged, neither the trust nor individual consultants could produce an accurate record of their clinical activity or outcomes for patients.

The trust made efforts to correct its short-comings – but to little effect. For example, as part of the plan for 2006/07, the trust asked its internal auditors to review the way complaints were dealt with. Reporting back in January 2008, internal audit was concerned that not »

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» all staff who conducted investigations into complaints had been trained in how to investigate. The auditors noted that complaints were not assessed in terms of their seriousness and recommendations and action plans arising from complaints were not clearly logged and monitored. In its report in March 2009, the commission says that the board "was largely unaware of" the number and seriousness of the complaints.

Aftermath

Healthcare professionals have been surprised at the extent of the failings at the trust. A spokesperson for Dr Foster says that "it is unbelievable that a trust had absolutely no idea that its patient mortality rate is so high and that it is left to an outside organisation – not even a regulator or commissioner of healthcare services – to point out from the hospital's own publicly available data that there is something very wrong going on at all levels of the organisation."

It is a sentiment shared by Katherine Murphy, director of health lobby group the Patients Association. She says: "How can any patient have trust in the managers and systems that have allowed this disaster to run and run? Clinical staff, struggling to cope, told management that action needed to be taken but they were ignored. It descended to the level where the majority didn't want to be treated by their own trust."

Monitor and the Secretary of State for Health Alan Johnson have launched two reviews of the trust. One of these will look into the roles and actions of South Staffordshire Primary Care Trust (PCT), which commissioned services from the trust, and West Midlands Strategic Health Authority (SHA), which is responsible for the supervision of the services that PCTs commissioned. Until that is complete and made public, neither the PCT nor SHA wish to pre-empt its findings.

But a spokesperson for West Midlands SHA says that "Strategic Health Authorities do not have access to the information that regulators such as the Healthcare Commission do. Disease specific alerts from the Healthcare Commission and Dr Foster were only shared with us at the end of January 2008". Stuart Poynor, chief executive at South Staffordshire PCT, has already indicated that the PCT is reviewing its own commissioning procedures and that it will use its contractual powers to serve performance notices where appropriate to drive up quality and experiences.

"Our approach to buying health services for the residents of South Staffordshire has developed and evolved considerably over the past eighteen months," says Poynor. "In our infancy we did what nationally was expected of us, using the Healthcare Commission Annual Health Check to reassure ourselves about the services we were purchasing. We also used the authorisation of the trust, by Monitor, as a foundation trust as reassurance that it was developing services of a high quality which best suited local needs. As we had received no direct complaints from patients or GPs, prior to the Healthcare Commission's investigation regarding services provided by the trust, we used this as a quality indicator."

Mid Staffordshire has already begun a root and branch review of its corporate governance framework. Eric Morton, the newly appointed chief executive of the trust, says that "we have made significant changes within a very short period of time and put in place new management, effective governance structures and made operational system changes in order to address the key issues of accountability, staffing levels and staff training."

Furthermore, directors at the trust have agreed to set up a board level healthcare governance committee to oversee continual improvements which will be chaired by a non-executive director. The board will also have regular meetings with members of the public to ensure that openness and transparency, customer satisfaction and community feedback is improved.

Monitor believes that "the trust now has the strong leadership it needs to respond to the report's recommendations" and has praised the trust's recent investments in new staff and equipment. But the Patients Association has yet to be convinced. Vanessa Bourne, head of special projects at the lobby group, says that "the entire board should have been swept away – not just the chairman and chief executive. How can anyone have confidence in board members that did not request in-depth data, or act on it when they got it? It's a disgrace." Mid Staffordshire may have gained trust status, but it will be a while yet before it wins back the trust of the community it serves. ●

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