Britain: Stafford General Hospital inquiry exposes impact of assault on NHS

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10 March 2010

A devastating report, delivered on February 23 into Stafford General Hospital, exposed conditions that one might expect in an underdeveloped country. The Francis Inquiry into the Mid Staffordshire Foundation Trust, which runs the hospital, revealed a catalogue of malpractices that could have resulted in the deaths of between 400 to 1,200 people over a three year period between 2005 and 2008.

Several inquiries and watchdog reports were launched into the high mortality rates at Stafford Hospital. The Hospital Standard Mortality Ratio (HSMR) was 27 to 45 percent higher than the national average. While the inquiry determined that it was not clear whether the high mortality rates were a direct product of negligence, which its remit did not permit, it raised alarm over the fact that there was no attempt at a serious investigation of the standards of care delivered which may have impacted on the high death rate.

Among the most serious failings of the hospital were filthy wards with blood and excrement encrusted on surfaces and inadequately trained nurses unable to operate cardiac monitors or intravenous pumps—meaning many patients did not receive the correct medication or the right dose of fluids.

Patients were “dumped” for hours and even days at a time in smaller units, without a dedicated nurse to care for them. There were too few consultants in Accident and Emergency to provide adequate cover and often there was no experienced surgeon in the hospital after 9pm.

The hospital even used unqualified receptionists to carry out the vital task of triage, in which patients are assessed for priority of care. One patient with an open fracture to the elbow was left for over four hours covered in blood with no pain relief.

The inquiry reiterated the earlier findings by the Healthcare Commission’s report in 2009 that patients were left lying in soiled sheets or on commodes, sometimes for hours, frightened and ashamed, as calls for help to use the bathroom were ignored. Some were left unwashed for up to a month, and others were left in pain, without drugs, and with food and drink out of reach. Staff failed to make basic observations and patients were often discharged before it was appropriate, which in at least one case ended in death.

The report, which runs to 900 pages and is based on evidence from more than 900 patients and 80 current and former staff, is a devastating indictment of the impact of Labour’s restructuring, privatisation and budget cuts since coming to office. The inquiry was held mostly behind closed doors and was not mandated to bring anyone to account. It was launched by Health Secretary Andy Burnham in order to dissipate the outrage and anger that the initial inquiry produced last year.

Many families of those affected by the appalling conditions denounced the inquiry as “toothless”, a “whitewash” and an attempt at a “cover-up”. They have been campaigning for a public inquiry and had demanded that the remit of the inquiry be far broader. Specifically, they wanted to know why other external organisations such as the Primary Care Trust, Health Commission and Health Authorities did not intervene at any stage, despite many complaints from patients and individuals.

The Francis Inquiry referred to these issues, but they were brushed aside. Its 18 recommendations focused on strengthening the inspection regime and a new round of target setting, which was one of the major factors that led to deterioration in patient care in the first place. The central role that the effort by the hospital to get “Foundation Trust Status” played in its dismal failings is also ignored. Burnham accepted all of the recommendations and defended the Foundation Trusts as “a privilege, not a one-way ticket.”

The evidence produced does, however, paint a horrific picture of the impact of the dismantling of public health services, both for employees and the millions reliant on it. Stafford is only the extreme expression of what is to come, as it is at an advanced stage in the privatisation of the NHS which confronts all health trusts throughout the country. There are a further 10 hospitals, both NHS Trusts and Foundation Trusts, which have a higher HSMR than Stafford and no investigation or inquiry has been demanded into these.

One of the most fundamental criticisms the inquiry raised, based on evidence gathered, was that in order to achieve Foundation Status, the trust management was obsessed with meeting government targets rather than looking after the sick in its care. Foundation Trusts were launched in 2003 by the Labour government as a means to end the system of centralised control and accountability, enabling individual hospitals to raise finance from the private sector and to determine their own wage rates and clinical priorities. Its aim is to introduce privatisation through the back door. In order for hospitals to achieve Foundation Status, they need to meet strict criteria bound up with reducing their budget deficits. It was when the hospital decided to apply to become a Foundation Trust that it spiraled from one crisis to another.

The report reviewed the culture of low morale and a tolerance for poor standards fostered by a management board focused on financial targets rather than patient welfare. This situation persisted even after the Healthcare Commission exposed the hospital's failings last March.

In answer to how staff allowed the appalling care to persist for so long, the report found those who spoke out were ignored and there was "strong evidence" that many were deterred from doing so through fear and bullying. Moreover, the restructuring of working conditions and cuts to staffing that had taken place during the time of the incidents can only be defined as conscious medical negligence. The majority of the complaints related to basic nursing care as opposed to clinical errors leading to injury or death. It was in this area that most restructuring had taken place.

The hospital was gripped by a financial crisis during that period. For months the trust had been struggling to overcome the legacy of a £10 million deficit, which had forced it to cut 150 jobs in order to balance the books. Although the trust board said most of the cuts were being made in managerial and support services in order to minimise the impact on front-line services, the Healthcare Commission's investigation found that during 2006/07 Stafford and Cannock Chase Hospitals (which is also run by Mid Staffordshire Foundation Trust) were in dire need of extra nurses. Their complement was short of 120 nurses, 17 of them in A&E, 30 in the surgical division and 77 on the medical wards.

The inquiry noted that before obtaining Foundation Trust Status, the board conducted a significant amount of business in private when it was questionable whether privacy was really required. "One particular incident concerning an attempt to persuade a consultant to alter an adverse report to the coroner has caused serious concern and calls into question how candid the Trust was prepared to be about things that went wrong," it noted.

Staff evidence tended to confirm the concerns raised by patients. Understaffing was a constant problem and staff even expressed their fear about losing their registration because of the unsafe care they were asked to deliver. Hospital staff had expressed opposition to a new ward configuration scheme that management imposed in 2006 as being driven by cost cutting and not safety. These concerns were dismissed. There was no risk assessment on the impact of the new pilot scheme on the care of patients and no review was conducted of its credibility despite continued opposition from nurses and staff. Its central feature was to shift the balance of work onto unqualified and inexperienced staff, whereby low-paid health care assistants predominated over nurses. The minutes of the board meetings which were viewed by the inquiry established that finance was the crucial factor in its implementation. Cost savings discouraged proper attention being paid to its impact on the safety and care of patients.

The health care assistants who replaced the nurses and some of the nurses themselves had not been trained to support the needs of many of the elderly and confused patients in their care. Staff had complaints about the incident reporting system. There was a lack of feedback and staff were discouraged from reporting mistakes. "There is little evidence that poor standards of nursing care were identified and discussed," the inquiry report noted.

A senior consultant, gastroenterologist Pradip Singh, in his evidence to the 2009 inquiry confirmed the impact of the cuts to nursing. He had been victimised for raising criticisms by the management board in 2008. In his evidence he said, "Over the years, many clinicians had noticed deterioration in the standards of patient care which became particularly acute approximately three years ago [2006] when major cut backs were made in staffing numbers. This included a savage reduction in the number of nursing staff."

He explained that following budget cuts, his department experienced "dozens of serious adverse clinical incidents resulting from abysmal secretarial support".

Dr Singh said that he and other consultants had complained to senior medical managers and the Trust's management, but the complaining doctors had been ignored and branded as troublemakers. He said a "palpable culture of intimidation" deterred others from speaking out publicly.

The second major area of concern and complaints was the Accident and Emergency ward. This area was subject to restructuring by a government scheme aimed at cutting costs. In 2005 the Labour government's health minister Lord Darzi proposed closing A&Es and centralising them. So-called "super-hospitals" would have to cater for the excess patients caused by the closure of local A&E services (such as Burnley General Hospital). Stafford Hospital had to bear the brunt of this scheme.

The Labour government's efforts to dismiss events at Stafford as a one-off do not stand. Daily similar events and experiences are being reported throughout the NHS and those who are reliant on the public health system can relate to at least one, if not many of the experiences witnessed by patients at Stafford.

The government has refused to organise an independent inquiry and is incapable of doing so as such an investigation would find it guilty of setting out to dismantle what remains of the NHS. Its "reform" agenda in health, education and other social services has been to starve them of funding and hand them over to private sector for exploitation for profit.