

Mid Staffordshire NHS Foundation Trust: surviving the storm

Paul Woodmansey

When I met people at conferences in the past and told them I worked in Stafford it was often met with a non-committal reply, remarks about the Shakespeare theatres (Stratford) or possibly a discussion about the Potteries (the site of the larger North Staffordshire hospitals). These days, people might still not know exactly where Stafford lies, but they are all too aware of its reputation. Stafford Hospital, or as it is more usually referred to in the press, the ‘beleaguered’, ‘troubled’ or ‘scandal hit’ Stafford Hospital, is a medium-sized district general hospital sited near the centre of a small town surrounded by beautiful countryside and a handful of small market towns. It is generally considered to be a pleasant place to live and bring up a family, lying in a rural oasis between the urban sprawls of the Black Country to the south and the Potteries to the north.

When the Health Care Commission (HCC) published its report in March 2009, this modest hospital was catapulted onto the front pages of national newspapers and politicians queued up to express their disgust on television and the radio.¹ There has been much discussion within the hospital and local papers as to whether some accounts of poor care were exaggerated, the use of hospital standardised mortality rate (HSMR) (one of the key concerns in the HCC report) has been strongly questioned and many colleagues elsewhere have expressed relief that it was our hospital not theirs which had received such in-depth scrutiny.² It is difficult for anyone to maintain objectivity in the face of such a media storm, and I suspect that similar instances of poor patient care could have, and perhaps can still, be found elsewhere. There was also no doubt that many, and I hope the majority, of patients who had been treated in our hospital had received good care. However, it soon became clear that the real position of the hospital in the national league of awfulness did not matter. What did matter was that many patients had received poor care and, for some, their treatment was appalling. The reason for this has been picked over at length but it essentially boiled down to poor managerial and clinical leadership in some areas, lack of clinical staff, particularly nurses, with inevitable low morale and, to some extent, lack of equipment.

What kind of hospital is Stafford at the time of writing in October 2010? Certainly not perfect, but by many measures vastly improved. In the Dr Foster report of 2009, the hospital was the most improved of the year and rates of methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile* had fallen dramatically.³ There are more consultant posts in the emergency department and the number of consultants in

acute medicine has increased. There has been a review of surgical specialties and a significant increase in nursing numbers. For the staff, it remains a work in progress and much is still to be done to regain the confidence of the local population.

While many poor judgements were made and the need to blame is entirely understandable, it is important to recognise that nobody who worked at Mid Staffordshire Foundation Trust came to work with the intention to do harm. However, the entire senior management team has since been replaced, many by short-term appointments. This has been necessary and helpful, but also unsettling. How can a hospital be turned round to succeed after such public failure and what can consultants who suddenly found themselves ashamed of where they work do?

How did we let it happen?

No doubt all the consultants in Stafford have asked themselves this question and it has arisen in many forums. There were certainly times when consultants raised serious concerns and it seems that ‘the management’ did not listen or did not act. We understood the very difficult financial situation and most of the time we did as many in the health service do, and got on with our daily jobs working very hard to make the best of difficult circumstances. It is important to understand that in most parts of Stafford Hospital patients were receiving good treatment, but it is sobering to realise how one can get used to such poor standards in other areas. In retrospect more of us should have made it clear that there were unacceptable staffing levels and practices in emergency care.

‘The new way of working’

If a hospital’s performance was measured by the number of visiting agencies visiting the place, Stafford would be by far the best hospital in the country. Of particular value to the consultant physicians was the help offered by Dr Ian Sturges and Russell Emeny of the interim management and support team and Professor Sir George Alberti who provided real inspiration. It seemed that this terrible situation could be turned into an opportunity to make genuine improvements. A small group led by myself and Dr Shaun Nakash in acute medicine realised that consultant input was the key to better and more efficient patient care. We practised the old model of the acute medical take which was run by a specialist registrar with a morning consultant-led post-take ward round the following day. In the summer of 2009 a few of us informally trialled a ‘new way of working’ in which all patients referred to medicine would be seen by the on-call consultant as soon as possible, ideally

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within two hours of referral. The assessment was recorded by a junior doctor on a specially designed page in the emergency care pathway which prompted the consultant to make a clear problem/diagnostic list, management plan and to estimate the date and time of discharge, whether venous thromboembolism prophylaxis was required and the most appropriate ward for the patient, or if community care was possible. After what seemed to be a successful trial, the entire consultant physician body accepted the new way of working and it was formalised from July 2009. The acute medical consultants manage the weekdays between 8.00 and 16.00 after which the on-call physician takes over and is present on the 'shop floor' from 17.00 to 20.30. A post-take ward round for all the night patients is carried out at 8.00 the following morning. This is consistent with the guidelines produced by the Royal College of Physicians (RCP) for managing non-elective care.⁴

In December 2007, we introduced a Saturday morning 'trouble-shooting' round in which the on-call consultant visited all the medical wards to see any sick patients and to aid weekend discharges. More recently a similar Sunday morning ward round has been introduced. The 'new way of working' at the weekends involves the attendance of the on-call physician in the afternoons and into the evening in addition to the Saturday and Sunday morning post-take rounds.

We do not claim that this approach is unique, but it has led to an increase in early discharges and appears to have coincided with a reduction in mortality including at the weekend (trust data).³ What has struck me particularly is the relative ease in which this major change to our working lives was introduced. So how did it come about? Consultants proposed the change and tried it and their colleagues quickly accepted that it was good for patient care. I have no doubt that it is the right thing to do if for no other reason than that despite it being harder work for us, no one has seriously suggested a return to the old system. The desire healthcare professionals have to 'do the right thing' for their patients should not be underestimated.

Work in progress

Having made some progress with the first 48-hour of acute medicine, we are currently focusing on care on the specialty medical wards. Perhaps the greatest challenge to consultant physicians (and our managers) is the recognition that a consultant-delivered, not led, service is required. I suspect that most people accept the principle, but the practice tends to be more difficult. It is necessary for patient safety and because of the pace of life in a modern hospital, including the need to reduce length of stay and our inability to rely on junior doctors (not meant as a criticism of our junior colleagues, but too large a subject for this article) means that our patients need senior input every day. This might be a discussion 'board round' for many, but should involve seeing all new patients on the ward, all sick ones and some of those planned for home. Many timetables (including mine) are set up in such a way as to make this difficult. However, daily review is best practice.^{4,5} I believe that we need to remember that the reason we have hospitals is to care for the

acutely ill and while outpatient activity is very important, the relative priorities, including financial ones, have become distorted. A patient with stable angina can wait a while with little risk. When a patient with an acute cardiac condition, severe enough to be in hospital, is admitted to my ward on Monday afternoon after my ward round, it is simply wrong for them to have to wait to see me until my next planned round on Thursday. I and my colleagues therefore squeeze in ward reviews and in-patient referrals in between other activities, but we are now working in job planning to make this core activity. (A daily cardiology round on the coronary care unit is longstanding.)

The role of other colleagues

I wrote this article at the kind request of the RCP and have therefore concentrated on the physicians' story. We are fortunate to work with excellent consultant colleagues in other specialties. Multidisciplinary team working underpins any success in modern healthcare and my colleagues and I highly value the nursing, technical, managerial and administrative staff who have enthusiastically worked with us through these difficult times.

A personal view

In my opinion a major underlying cause of the 'Stafford scandal' was that most of us, including politicians and healthcare professionals, had lost sight of the fundamental priority of a national health service. That is to provide excellent and immediate care to those who become suddenly very unwell. There have been tremendous improvements in many areas such as cardiac, cancer and orthopaedic care. However, the importance of the care of sick elderly patients who make up the bulk of our medical 'takes' have only rarely grabbed the headlines. Care of these patients is expensive in staff time and resources, it is often difficult and tiring and can only be delivered in a high-quality way by departments which are equipped appropriately, are well staffed by motivated individuals and led by enthusiastic consultants.

What are the lessons to learn?

It might be comforting to imagine, but no one should fool themselves into thinking, that the problems which occurred in Stafford were unique. Our hospital did not have the worst HSMR in the country during the period under investigation and I suspect that a powerful pressure group and an in depth HCC assessment might turn up similar horrors elsewhere. Delivery of good healthcare is difficult, particularly in the pressured environment of emergency care.

Much as I would love to return to the relative anonymity of old, politicians, healthcare managers and clinical staff must not forget the lessons of Stafford. What does it say about this still rich country if we cannot fund sufficient nurses and doctors to look after our sick and elderly when they most need it? As consultants we are the ones who need to lead change and we are the most powerful advocates for our patients and sometimes have to

muster the courage to state loudly and clearly when 'care' is simply not good enough.

References

- 1 Commission for Healthcare Audit and Inspection. *Investigation into Mid Staffordshire NHS Foundation Trust*. London: Commission for Healthcare Audit and Inspection, 2009.
- 2 Lilford R, Pronovost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. *BMJ* 2010;340:955-7.
- 3 Dr Foster. *The Dr Foster hospital guide 2009: how safe is your hospital?* London: Dr Foster, 2009.
- 4 Royal College of Physicians. *Acute medical care. The right person, in the right setting – first time. Report of the Acute Medicine Task Force*. London: RCP, 2007.
- 5 NHS Interim Management Support Team. *Planning for predictable flow of patients into unscheduled care pathways beyond the emergency department: meeting demand and delivering quality*. London: DH, 2010.

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Working party report

Medical rehabilitation in 2011 and beyond



This working party report, published by the Royal College of Physicians with support from the British Society of Rehabilitation Medicine, examines the current state of rehabilitation medicine, and considers how it is likely to develop over the coming years.

The report revises the definitions around rehabilitation medicine, in line with current practice. It also places rehabilitation in the broader context of acute illness management, arguing that commissioning – in the format newly proposed by the coalition government – should support interdisciplinary practice and clinical pathways which reflect the widespread overlap with other areas of medicine. Standards of practice are also discussed in the context of the National Service Framework for long-term neurological conditions. The report argues that, while shorter-term programmes are functioning well, longer-term pathways need to integrate high-intensity treatments, greater consideration of the individual's participation in life, vocational needs, family relationships, and the need to return to as normal a life as possible.

Empirical proof of the effectiveness of rehabilitation is hard to gather. This document draws on evidence from a wide range of papers, reviews and Cochrane collaborations, to support the argument for increased

'The report will help health professionals in accessing rehabilitative care for patients by improving understanding of clinical pathways, the field of competence and the role of rehabilitation specialists within teams'

Professor Amanda Howe, RCGP

investment in rehabilitation medicine for the future, embracing technological innovations and providing high-quality, personalised care.

This report is essential reading, not just for rehabilitation medicine physicians, but also specialists in stroke, palliative, acute and geriatric medicine, and neurology. It also contains guidance for current commissioners, planners and providers of healthcare and social care, and for GPs for their clinical practice as well as for their commissioning work in the near future. ■

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