POLICY

Nursing notes on a scandal

Authors: Anne Marie Rafferty[A] and Alison Leary[B]

ABSTRACT

10 years on from the publication of the Francis report, the nursing profession is facing unprecedented challenges; Robert Francis has recently sounded the alarm that the NHS is currently facing 'the Mid Staffordshire scandal playing out on a national level'. In this perspective, we consider the opportunities missed in the last decade in the attempt to secure safe staffing in nursing.

KEYWORDS: nursing, Mid Staffordshire, Francis, patient safety, safe staffing

DOI: 10.7861/fhj.2023-FR102

The tenth anniversary this year of the publication of the Francis Report in 2013[1] is marked by the largest scale of industrial action ever taken by nurses in the UK for better pay and conditions and, especially, safe staffing.

Nursing at Stafford Hospital was at the eye of the storm of the Mid Staffordshire scandal, with some of the most egregious failures in care joining the back catalogue of the worst atrocity stories in healthcare history. Nursing numbers were cut, with a reported loss of some 150 staff, in an effort to balance the books and gain the prized badge of foundation trust status. Low staffing levels were allowed and enacted by a combination of bullying and intimidation, which hobbled the nursing voice and leadership and led to their consequent failure to raise the alarm. Later, fault was also found with the Royal College of Nursing (RCN) for its lack of pace and strength of response to the failings at multiple levels. Criticism was aimed at the dominance of the trade union, to the detriment of the professional arm of the Royal College.

10 years later, on 6 January 2023, the chair of the Patients' Association, Sir Robert Francis, and the CEO of the Patients Association, Rachel Power, wrote in a letter to the secretary of state for health, Steve Barclay: 'the current crisis in the NHS is a serious threat to patient safety and, it is clear that lives are being lost as a result… what we are witnessing across the NHS is the Mid Staffordshire scandal playing out on a national level.'[2] They urged the government to take action to prevent the NHS ever again experiencing this sort of crisis. It is hard to find a more incriminating accusation of a direct line of descent between the scandal that shook UK healthcare to its very core and the tenth anniversary of the Public Inquiry into Mid Staffordshire NHS Foundation Trust. What was supposed to be a never event is repeating itself on a wide scale.

The aftermath of the public inquiry into Mid Staffordshire NHS Foundation Trust and its consequences for nursing is a story about evidence, campaigning, journalism and missed opportunities. In this perspective, we consider the dynamics surrounding the attempt to secure safe staffing policy for nursing and put in place policies and guidance to attain this. This not an exhaustive analysis (an excellent overview has been provided by Lawless and colleagues.[3]) Rather, it is a reflection on some of the opportunities that could have put nursing on a different footing to the one that impelled Robert Francis and Rachel Power to write a letter of such condemnation to the secretary of state for health. The authors have also seen how a growing body of evidence around safe and effective staffing is robustly ignored by policy makers, employers and workforce planners. Frontline expertise, the proficient workforce that promotes safety and manages risk, is seen as more expensive even when it is a good return in investment.

The Francis report made 290 recommendations and the response to Francis brought about initiatives such as Freedom to Speak Up, changes to regulatory practices by the Care Quality Commission, and a response from government that it would learn from the findings. Some of the work has been embedded and some, for example the assumptions around clinical outcomes being poorer at weekends, turned out to be much more complex and associated as much as with care outside of hospital as care inside.[4] Some 8 months after the inquiry's publication, nurse staffing policy guidance was published by NHS England's National Quality Board (NQB), an oversight body set up to monitor quality.[3,5] A framework and tools for decision-making were outlined, but significantly, ratios were rejected over 'evidence, evidence-based tools professional judgement and a multi-professional approach.'[5]

Francis had taken oral and written evidence and held seminars on nurse staffing during the Inquiry. There was a great deal of interest taken in the strength and quality of the evidence base on nurse staffing and links to patient outcomes, with a further review commissioned by the then medical director of the NHS in England, Sir Bruce Keogh, that also flagged troubling concerns on nurse staffing.[6] Yet the Francis report did not make specific recommendations on staffing policy. Rather, it asked the National Institute for Health and Care Excellence (NICE) to review the evidence and make recommendations on policy. Providing a review of this kind was something of a departure for NICE, as its previous focus was on clinical rather than workforce

Authors: [A]professor of nursing policy, Florence Nightingale Faculty of Nursing, Midwifery & Palliative Care, King's College London, London, UK; [B]chair of healthcare workforce modelling, London South Bank University, London, UK

© Royal College of Physicians 2023. All rights reserved.

issues, though its methodological approach was relevant. The first area to be covered by NICE was acute adult inpatient care. This was also the area in which the evidence was strongest. A meticulous and comprehensive review, including the economic case and evidence, was produced by a team at the University of Southampton. There was a lot riding on the review. Importantly, minimum nurse staffing levels had been excluded from the scope of guideline development.[3] The 2014 NICE guidance on safe staffing for nursing in adult inpatient wards in acute hospitals identified several organisational and managerial factors that were necessary to support safe nurse staffing.[7] It also outlined a series of indicators, or nursing 'red flag' events, to assess whether the level of nurse staffing was enough to meet patients' needs safely and to warn of potential shortfalls in staff numbers. The guidance stated that a ratio of 1:8 patients during the day on an acute ward was associated with an increased risk of harm to patients and should prompt monitoring of the nursing red flag events and action to ensure staffing was adequate. The guidance was accompanied by an endorsement of the Safer Nursing Care Tool (SNCT). Broader concern with productivity in the NHS had spurred a report by Lord Carter, which highlighted unwarranted variations in nursing as one of its focal points.[8] What happened next was quite unprecedented. On 4 June 2015, NICE suspended work on the reviews with immediate effect. This coincided with an announcement by the NHS chief executive at the time that the then chief nursing officer (CNO) would include safe staffing as part of a wider set of service reviews. This seems to have been sparked by the recommendation of ratios in the draft guidance for emergency departments. It was suggested that the takeover would avoid a 'more mechanistic approach of nurse ratios.' Robert Francis responded that this would undermine the rationale for asking NICE in the first place: to adjudicate on safe staffing on account of its evidence based, analytical and independent approaches.[9]

The decision to suspend the NICE work on safe staffing seemed political. The key fear from official circles seemed to be the introduction and use of ratios by the back door, despite their use in most other safety-critical industries, and the consequences for agency and overseas recruitment spend if any kind of minimum staffing ratio became mandatory.[9] The mantra of maintaining quality within available resources put the onus on clinicians and boards to manage risk and to make trade-offs between quality and safety and costs. This was followed by a chorus of criticism from the Safe Staffing Alliance, a coalition of nurse directors, journalists, workforce researchers and academics.

The secretary of state responsible for implementing the findings from the Francis Report, Jeremy Hunt (now chancellor of the exchequer), affirmed a commitment to safety and the report's findings. He was adamant he would personally ensure progress on safe staffing continued, stating: 'Whoever is responsible for that work, I will hold their feet to the fire to ensure we continue the excellent progress made on safe staffing.'[9] Hunt said he supported NHS England's decision to ensure a 'better way of measuring safe staffing that is more subtle than simply numbers of bodies per shift', but how was that commitment met?[9]

10 years on, has much changed in terms of patient safety? Sir Robert Francis still receives requests from relatives and staff looking for help to address patient safety issues or ways of dealing with managers who put pressure on staff to keep quiet despite the legal duty of candour. In an interview recently with Shaun Lintern, the Sunday Times journalist who exposed the Mid Staffs scandal, Robert Francis tells of accounts of atrocious care. One of his main concerns was how NHS staff were being treated: 'There is hardly anywhere where the staff are properly looked after in terms of their wellbeing, health, and basic welfare, such as food and drink. They have to go on strike to get listened to.'[10] Francis also fears the impact of the pressure on the human beings who provide the service is 'that inhumane things are bound to start happening and are happening on a much wider scale than we had at Mid Staffs.'[10] Francis said that fundamental changes are now needed to the way care is organised and delivered and that that would need a big conversation with the public about what that could mean. He has also said NHS trusts need to examine how they could make the lives of their staff better irrespective of pay.

Recent reports and subsequent inquiries into other failings, such as the serious case review at Winterbourne View,[11] the Mid Essex Mental Health Inquiry,[12] reviews of maternity services by Donna Ockenden at Telford and Shrewsbury,[13] and the ongoing inquiry into the failings at Muckamore Abbey Hospital,[14] show that the events of Mid Staffordshire were not lone issues. Indeed, before Mid Staffs there were other Inquiries as far back as the Ely Hospital Inquiry in 1969.[15] The findings were equally sobering: 'Inhumane and threatening behaviour by staff members towards patients, lack of trained staff, mistreatment of patients by staff more generally and lack of care and indifference on the part of senior staff to complaints.'[15] Recurring themes persist: the number of staff, the educational/skill levels of staff, workloads, poor leadership, workplace culture, the normalisation of poor care, and, no doubt those that cite staffing issues just in the case of Mid Staffs, financial performance. The safety researcher Erik Hollnagel puts it bluntly. In healthcare, safety is not income-generating.[16]

Despite the many inquiries, the NICE evidence reviews, and the many published papers, the precautionary principle never applies to workforce. The NHS is not seen as safety-critical from either within or without. Its workforce is modelled as a service industry. The precautionary principle is important in high-risk, high-harm, safety-critical work and so where precautions are taken until safety is proven, is the usual approach. Pragmatism and a measured approach to risk often apply. A lot of safety legislation in other industries is either tombstone legislation or precautionary. It is different in healthcare, where the status quo applies until something is proven dangerous and harmful. The burden of proof is often high and often falls to the workforce to 'prove'. it's still up to the workforce to prove the risk, rather than policy makers heeding the evidence and erring on the side of caution.

Another factor is healthcare's commitment to the internal market and Taylorism: the idea that work is discrete, task-based and fits into a production line with technical competence as the only qualification for the work. This oversimplifies complex safety-critical work and underestimates the actual workloads or the knowledge-intensive nature of the work. Thus, the workforce suffers increasingly from skill dilution, or the addition of less skilled hands for less money. Indeed, at Mid Staffs, Winterbourne View, and most of the other inquiries, a deficit of senior leaders is a common finding.

Francis has referred to the voice of nursing as being too weak and not given the respect it deserves: 'I think it's absolutely vital that there is a professional voice of nursing, which is listened to in relation to standards, which is distinct from the trade union. It was a problem at Mid Staffs that the nursing voice was not heard.

© Royal College of Physicians 2023. All rights reserved.

I think chief nurses do not have the status they should have, and the chief nursing officer does not have the status she should.'[10] This was seen as a subset of a broader problem: there was 'general pressure on national leaders to toe a line rather than expressing an independent voice.'[10] Some would say that the professional voice of nursing is still weak and has permitted frontline skill dilution and devaluation of the role of the registered nurse. Only recently, in the form of industrial action, have nurses begun to find their collective voice.

In many ways the issue has come full circle. There is pressure on employers to cut the spend once again through the workforce budget, despite rising costs generally. In their recent letter to the secretary of state for health, Robert Francis and Rachel Power insisted the government must publish the long-term workforce plan for the health and social care system that we've been waiting for.[2] They remind him 'there is no shortage of ideas about how to mitigate against some of the worst cases of terrible care resulting from underfunding exhausted staff, high numbers of unfilled posts and ever-growing waiting lists', yet 10 years on, these lessons lie mostly unheeded and the consequences could be catastrophic.

It is worth considering the counterfactual and speculation on what would have happened had the NICE work been allowed to continue. Would we see ~47,000 vacancies and declining numbers of students stepping forward to enter the nursing profession? The introduction of staffing legislation in Wales (2016) and Scotland (2018) has not prevented staffing being part of the case for industrial action. Neither of these legislative models have been able to mandate minimum staffing levels, though undoubtedly they are a step in the right direction. The RCN has published its safe staffing standards, which provides guidance on escalation and expectations across a range of settings, but the floor is not firm or stable.[17] The evidence has moved on in the intervening period. A pilot trial in Ireland and pre- and post-evaluation of a staffing mandate for minimum ratios in the State of Queensland add weight to the methodological rigour, which was missing when NICE published their review in 2014.[18,19] Ratios provide a safety net and better outcomes for patients and nurses, including nurses' own health outcomes, which is at a premium in the aftermath of the pandemic.[20] They are an investment in staff health and wellbeing and have not driven escalating costs. Current staffing guidance has not solved the staffing crisis. It still puts the onus of risk and responsibility firmly onto the shoulders of hard-pressed clinicians, nurse managers and boards. The efforts to resist ratios in the intervening years seems to have led us into the current crisis. We are running out of options to secure workforce supply to meet growing demand. Something tangible and solid is needed. The long-awaited workforce plan seems like a mirage. Now is the time during industrial action and negotiations to put nurse staffing on a stable and secure footing with the funding to match and future proof the NHS for its next 75 years. While evidence in a post Francis study demonstrated some improvement in nursing numbers post Francis, these were more evident in support staff, diluting skill mix and still being outpaced by demand. The tight labour market and acute shortages of staff imperil patient safety and staff wellbeing and act as a brake on improvement.[21] Tinkering without improving the labour market conditions and investment will not provide a long-term solution.

In marking this anniversary, it is important to pay tribute to the campaigning journalism of Shaun Lintern in his various posts at newspapers ranging from the *Express & Star* to *The Sunday Times*. In a podcast, Lintern sets out the trajectory of the Inquiry.[22] It reminds us of the role that that veteran campaigner William Russell revolutionised war reporting during the Crimean War. In his despatches he described in graphic detail the appalling carnage and conditions of neglect for British soldiers during the various battles of the war. The public outrage that ensued pressured the government to act. Without his graphic descriptions it is unlikely Florence Nightingale would have set sail with her 38 volunteers to Balaklava.[23] Sir Robert Francis too has been relentless in his pursuit of justice and speaking out from different positions he has held since leading the Inquiry: board member of the Care Quality Commission, chair of Healthwatch and trustee of the Florence Nightingale Foundation and the Patients' Association. But most of all we should memorialise those who died and the trauma faced by them and their families. The campaign 'Cure the NHS', mounted by Julie Bailie in response to the appalling care received by her mother Bella, is what triggered the Inquiry and their courage should also be honoured. The human costs have been high and we should hold Jeremy Hunt's feet to the fire as chancellor of the exchequer. He has the means to change the trajectory of policy. With a pay deal and safe staffing legislative framework proposed to end the current industrial dispute, he needs to support that and provide the funding for a workforce plan to set us on a better course for the future. ■

Acknowledgements

Many thanks to Professor Jane Ball and Shaun Lintern for insights shared via interview to inform this analysis and Natalie Sanford for editorial assistance.

References

1. Francis R (chair). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. UK Government, 2013. Available from www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry [Accessed 16 March 2023].
2. Francis R, Power R. *Letter to the secretary of state*. Patients' Association, 2023. www.patients-association.org.uk/news/declare-a-national-incident [Accessed 16 March 2023].
3. Lawless J, Couch R, Griffiths P, Burton C, Ball J. Towards safe nurse staffing in England's National Health Service: Progress and pitfalls of policy evolution. *Health Policy* 2019;123:590–4.
4. Bion J, Aldridge C, Beet C *et al*. *Increasing specialist intensity at weekends to improve outcomes for patients undergoing emergency hospital admission: the HiSLAC two-phase mixed-methods study*. Health Services and Delivery Research, 2021. www.ncbi.nlm.nih.gov/books/NBK571870/ [Accessed 16 March 2023].
5. National Quality Board. *How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability*. NHS England, 2013. www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf [Accessed 16 March 2023].
6. Keogh B. *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. NHS England, 2013.
7. National Institute for Health and Care Excellence. *Safe staffing for nursing in adult inpatient wards in acute hospitals*. NICE, 2014. www.nice.org.uk/guidance/sg1.
8. Carter PR. *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*. Department of Health and Social Care, 2016. www.gov.uk/government/publications/productivity-in-nhs-hospitals [Accessed 16 March 2023].

© Royal College of Physicians 2023. All rights reserved.

9 Lintern S. Francis criticises cessation of NICE work on safe staffing guidance. *Nursing Times*, 5 June 2015. www.nursingtimes.net/roles/nurse-managers/francis-criticises-cessation-of-nice-work-on-safe-staffing-guidance-05-06-2015/ [Accessed 16 March 2023].
10 Lintern S. *10 years on: An interview with Sir Robert Francis*. Nuffield Trust, 2023. www.nuffieldtrust.org.uk/news-item/interview-with-sir-robert-francis [Accessed 16 March 2023].
11 Flynn M. *Winterbourne View Hospital: A serious case review*. South Gloucestershire's Safeguarding Adults Board, 2012. http://sites.southglos.gov.uk/safeguarding/adults/i-am-a-carerrelative/winterbourne-view/ [Accessed 16 March 2023].
12 Essex Mental Health Independent Inquiry. *An independent inquiry into the deaths of mental health inpatients in Essex between 2000 and 2020*. www.emhii.org.uk/ [Accessed 16 March 2023].
13 Ockenden D (chair). *Ockenden review: summary of findings, conclusions and essential actions*. Department of Health and Social Care, 2022. Available from www.gov.uk/government/publications/final-report-of-the-ockenden-review [Accessed 16 March 2023].
14 *Muckamore Abbey Hospital Public Inquiry*. www.mahinquiry.org.uk/ [Accessed 15 March 2023].
15 Howe G. *Report of the committee of enquiry into allegations of ill-treatment of patients and other irregularities at the Ely Hospital, Cardiff*. UK Government, 1969.
16 Hollnagel E. *Synesis: the unification of productivity, quality, safety and reliability*. Routledge, 2021.
17 Royal College of Nursing. *Nursing workforce standards: supporting a safe and effective nursing workforce*. RCN, 2021. www.rcn.org.uk/professional-development/publications/rcn-workforce-standards-uk-pub-009681 [Accessed 16 March 2023].
18 Ireland Department of Health. *Framework for safe nurse staffing and skill mix in general and specialist medical and surgical care settings in adult hospitals in ireland 2018: final report and recommendations by the taskforce on staffing and skill mix for nursing*. Department of Health, 2018.
19 McHugh MD, Aiken LH, Sloane DM *et al*. Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals. *Lancet* 2021;397:1905–13.
20 Lamb D, Gafoor R, Scott H *et al*. Mental health of healthcare workers in England during the COVID-19 pandemic: a longitudinal cohort study. *medRxiv* 2022:2022.06. 16.22276479.
21 Ball J, Barker H, Burton C *et al*. *Implementation, impact and costs of policies for safe staffing in acute NHS Trusts*. University of Southampton, 2019.
22 *The scandal that shook the NHS [Podcast]*. https://shows.acast.com/storiesofourtimes/episodes/the-scandal-that-shook-the-nhs.
23 Rafferty AM, Wall R. An icon and iconoclast for today. In: Nelson S, Rafferty AM (eds), *Notes on Nightingale: the influence and legacy of a nursing icon*. Cornell University Press, 2010.

Address for correspondence: Professor Dame Anne Marie Rafferty, 57 Waterloo Rd, London SE1 8WA.
Email: anne_marie.rafferty@kcl.ac.uk
Twitter: @annemarieraffer

© Royal College of Physicians 2023. All rights reserved.