RETURN TO THE KILLING FIELDS

A chronicle of deaths foretold

Sir David Nicholson, the NHS chief executive who refuses to resign, once joked that Andrew Lansley’s disastrous NHS reforms were “so big, you can see them from space”. On that basis, the Mid Staffs scandal is so rotten you can smell it from space.

When the Bristol heart scandal whistleblower Dr Steve Boulton was asked in 1998 how to avoid future disasters in the NHS, he said simply: “Never lose sight of the patient.” Thirty-five babies died in Bristol due to substandard care over a four-year period, and the unit was dubbed “The Killing Fields” by staff (as revealed in Eye 793). A decade and a half later, Robert Francis QC has found that 1,197 people died at Mid Staffordshire hospital between 1996 and 2008, 492 of those deaths happening between 2005 and 2008. How could the NHS, with record funding, published death rates and armies of regulators lose sight of so many patients, some of whom died in appalling conditions? And who is responsible? Francis provided detailed answers to the first question and completely ducked the second.

In avoiding any direct criticism of named policies, politicians or senior NHS managers who oversaw this lengthy disaster, Francis has put another nail in the coffin of accountability in the NHS. The fact that no one in the Department of Health saw the need to accept responsibility and resign over Mid Staffs shows a staggering lack of insight.

Most hospital chief executives the Eye has spoken to think Nicholson should resign; but all are too frightened or simply “not allowed” to say so publicly, such is the culture of fear in the NHS. There are plenty of brilliant managers who would do a far better job than Nicholson, but they won’t get a chance. Nicholson, remember, was the interim chief executive of the health authority overseeing Stafford Hospital in August 2005 and, later that year, sat on the panel that appointed the cost-cutting chief executive Martin Yates. Nicholson then strolled into his next job as chief executive of the NHS Commissioning Board unopposed.

The sense of relief among politicians on both sides at the “no one at the top to blame” line was palpable. David Cameron dodged out platitudes and called on the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) to strike off incompetent or callous frontline staff – but any competent regulator would have done so already. Health secretary Jeremy Hunt says he wants police to investigate the hospital; but the NHS generals whom both Labour and the coalition have shared, are sitting pretty. What smells like corporate manslaughter gets washed away, as far from Whitehall as possible.

Ignoring Francis already

Francis was commendably insistent that the legally-enforced gagging of whistleblowers must end (see Shoot the Messenger, Eye 1292) – a practice Commons health select committee chairman Stephen Dorrell accepts is “corrupt”. But the NHS is at it again.

On 14 February Gary Walker, the former CEO of United Lincolnshire hospital (one of 14 trusts being belatedly investigated for persistently high death rates), bravely broke his gag to tell Radio 4’s Today programme how he had been bullied, sacked and silenced for saying how targets for non-emergency patients were endangering emergency admissions.

His story implicates both Nicholson (to whom Walker had written, warning him of the dangers) and his managing director of commissioning, Barbara Hakin OBE, who was CEO of East Midlands SHA. The BBC put the allegations to the Department of Health, and within hours a letter from the trust’s lawyers threatened Walker with the loss of all his pay-off if he didn’t shut up.

Last June the Eye referred Dr Hakin to the GMC for failing to protect either Walker or him, and the GMC is investigating at the customary speed of a glacier. Dorrell, as select committee chair, told Today’s John Humphrys that he had been “in correspondence” with Walker for two years. Walker claims Dorrell never replied to his letter and must now be called in front of the committee to hear his evidence against Hakin and Nicholson. The committee must also ascertain if anyone at the DoH tipped off the trust or its lawyers, Beachcroft, who issued the sinister and threatening letter to Walker.

Knighthood for a whitewash?

One wonders what version of his report Robert Francis was reading at the press conference on 6 February. He looked like a man held hostage. The interminable delay in publication to allow for rewrites has reportedly been because those he was minded to criticise had launched vigorous legal defences. In the end he opted for a ridiculous “no scapegoats, blame the system” approach. This was endlessly debated after the Bristol Inquiry report in 2001, when a culture of “fair blame” was proposed. Ill thought-out, untested, rushed and brutality-enforced reforms undoubtedly contribute to NHS disasters, but individuals also have to be held accountable for their actions. Patients and staff trust a system that is just. But the judge delivered no justice.

Had Francis had the time to wade through the Bristol Inquiry evidence, he would have found where to point the finger. On 9 February 2000, Rohan Pirani, lead counsel for the Department of Health, delivered an unequivocally clear statement of accountability: “It is never too late, in the area of responsibility and accountability, and make it absolutely clear that the Department of Health accepts that it is responsible for accountability and connected for any processes that were in place during the period covered by the Inquiry. Ultimate responsibility rests with the Department of Health and the secretary of state.”

This has not been followed; the Francis Inquiry was a final chance to make the NHS accountable to patients and it has failed.

Lest we forget

If you only have time to read one Francis report, make it his first independent inquiry, published in February 2010. The stories behind the harm are staggering. An old man forced to stay on a commodore for 55 minutes wearing only a pyjama top; a woman whose legs were “red raw” because of the effect of her uncleaned faeces under her nails asked for them to be cut, but was told that it was “not in the nurses’ remit to cut patients’ nails”.

Another woman who found her mother with faeces under her nails asked for them to be cut, but was told that it was “not in the nurses’ remit to cut patients’ nails”. The care was so bad that as many as 1,200 people died unnecessarily, often in appalling conditions. The poor care was known about for years and flagged up by successive mortality data alerts. The problem was that no one acted on the data or listened to the patients and relatives. And whistleblowers
were threatened and silenced. Whoever oversaw such a climate of fear in the NHS has to go.

Nicholson refuses to budge

David Nicholson has been chief executive of the NHS since 2006, and of the strategic health authority that oversaw Mid Staffs beforehand. Having sat on the appointment panel that decided Martin Yeates would be a good CEO, his fingerprints are all over Mid Staffs. But despite being the accountable officer for the NHS, Francis decided he wasn’t accountable.

Nicholson’s statement to the most recent public inquiry said: “The point at which I became aware of the extent of the Healthcare Commission’s concerns about patient care at [Mid Staffs] was shortly after Sir Ian Kennedy met with Alan Johnson [former Labour health secretary] on 4 February 2009.” And yet Francis heard evidence that in May 2008, representatives from the Healthcare Commission, including Sir Ian Kennedy, had met with Nicholson and “had an overwhelming response from local people on the questions of quality of care” at Mid Staffs, particularly from Cure the NHS. Nicholson could hardly “remain alive to something which was simply lobbying... as opposed to widespread concern.” Nicholson does not recall saying that in his evidence.

“The board of Mid Staffordshire failed in its statutory duties to provide good quality care and managing within the resources provided. That no other hospital failed so profoundly and persistently in this period, serves to emphasise the singular rather than the systemic nature of this case.”

The inquiry counsel’s closing submission said: “There seems little likelihood for other examples within the health service of poor management, poor governance and poor care and it is the system that failed them. This approach is supported by the many letters which the inquiry has received from all over the UK about failures of care in other trusts... with respect to him [Nicholson], this seems to us to be a very dangerous attitude to take.”

The fact that 14 other hospitals that have had high death rates for years but are only now being investigated (because how much bigger the problem is than Mid Staffs. The DoH has belatedly realised that avoidable deaths is a bad thing.

Francis accepted in his evidence that the NHS had been too focused on finance: “Quality was not the organising principle of the NHS, it wasn’t the thing that was driving us day-to-day.” Even the Department of Health and Labour government noted the recommendations of the Bristol Inquiry, it certainly would have been.

From Bristol to Mid Staffs and back

Bristol and Mid Staffs have similarities, in that the problems dated back a decade before any action was taken to protect patients, despite many levels of the NHS being aware of the poor care and high death rates, or at least having access to a sea of data that pointed to a serious problem, if only they’d been bothered to look.

In both, the scandals would have remained buried had it not been for a highly organised, determined and ethical group of relatives who simply would not go away until they got a public inquiry. As with Bristol, the biggest danger to patients in the NHS would be to dismiss it as an isolated incident in one hospital. Appalling care still occurs in pockets across the NHS, but in the absence of effective regulators, it usually only comes to light if patients, relatives or whistleblowers make an extraordinary effort to expose it.

In Bristol, whistleblower Steve Bohns was prepared to sacrifice his career by taking his concerns outside the hospital when its managers refused to act. Despite legislation designed to protect whistleblowers following Bristol, such action remains a career death wish in the NHS. The few staff who tried to blow the whistle on Mid Staffs were bullied, threatened and in one case suspended, in an attempt to keep the scandal “in house.”

That attempt was futile because the appalling care was so obvious to patients and relatives. In Bristol, no one doubted that the surgeons were trying their best, but their best was simply not good enough and they lacked the insight to stop when there was clear evidence that too many babies were dying. At Mid Staffs, some staff still managed to deliver compassionate care in the most stressful circumstances; many became terse and uncaring when their working conditions were terrible; and a few simply shouldn’t have been working in the NHS. Unnecessary deaths did not just occur in a war zone emergency department or because of careless neglect of the elderly, but across all age ranges and in many specialties, including surgery, some of which was “grossly negligent”, according to the Royal College of Surgeons.

Mid Staffs is currently one of many bust trusts, struggling on government handouts and shutting its emergency department overnight to save money and lives. It was always too small to be viable as a foundation trust; and the disastrous decision to push it down that route contributed to staff cut-backs that made the hospital so dangerous, and breed a culture of denial, demotivation and desensitisation. Twenty-one years after the Eye broke the story of the Bristol scandal, child heart surgery still hasn’t been safely re-established in a better resourced unit. Bristol is in trouble again, with further allegations of avoidable deaths, harm and understaffing in its child heart surgery unit.

Asleep at the wheel or willfully blind?

After the Bristol Inquiry, campaigners tried to pursue a charge of corporate manslaughter against the NHS, a charge that requires “a controlling mind” being willfully blind to the suffering, rather than just asleep at the wheel.

The politicians were clearly asleep – none more so than Andy Burnham (pictured above), Labour health secretary from 2001-02 to 2007-08 were all significantly higher-than-expected death rates quickly and thoroughly. This message was later reinforced by Sir Michael Coghlan, who warned the Department of Health that “The DoH and Burnham claim they were openly published online and in the Daily Telegraph. The DoH and Burnham claim they were completely unaware of them. Unbelievable.

The importance of death

In 2001, the Kennedy Inquiry into Bristol had made 198 recommendations about safe and humane healthcare that could have been cut and pasted into the Francis report, leaving him just another 92 to come up with. Sir Ian observed: "There seems little likelihood for other examples within the health service of poor management, poor governance and poor care..."

Death is only one measure of the quality of healthcare, but it’s a crucially important one. It’s relatively easy to spot, one-off, irreversible and when avoidable – it’s the biggest harm the NHS can do to you. It also must be registered by law, so it’s harder to hide in the chains of inaccurate and ‘missing’ handwritten NHS records.

It was a comparison of death rates in different units that revealed the Bristol heart scandal; but it was only when Private Eye published them in 1992 that action started to be taken. When the unit was finally staffed properly in 1995 with careful monitoring of results, the death rates came tumbling down from 29 percent to 4 percent in two years.

A key lesson from Bristol was that a vital step to a safe NHS was accurate, publicly available comparison of quality across the service, combined with a duty to investigate higher-than-expected death rates quickly and thoroughly. This message was later reinforced by Sir Michael Coghlan, who warned the Department of Health that “The DoH and Burnham claim they were openly published online and in the Daily Telegraph. The DoH and Burnham claim they were completely unaware of them. Unbelievable.

In hospitals, at least, Standardised Mortality Ratios (SMRs) have been measured since the mid-1990s, and published annually by Dr Foster since 2001, in collaboration with Professor Brian Jarman and Paul Aylin at Imperial College. A score above 100 is higher than average. The 1996 HSMR for Mid Staffs was 108. The HSMRs from 2001-02 to 2007-08 were all significantly high. These figures were in the public domain, available to all who cared to look. The Department of Health and successive Labour health secretaries (Alan Milburn; John Reid; Patricia Hewitt; Alan Johnson; and Burnham) should have been there, with their fingerprints all over Mid Staffs, reminding them with their NHS chief executives (until September 2006 Sir Nigel Crisp; then Nicholson).”

High SMRs for one hospital belie the notion that poor care is the result of rare, exceptional failings. There is a strong correlation between the number of avoidable deaths and the number of deaths due to lack of resources. And the converse is true: increasing resources and staffing correlate precisely with decreasing death rates.

Understanding of how the system works for judging NHS trusts’ suitability for foundation status operated “differed from the reality”. His “belief that it did not just occur in a war zone emergency department or because of careless neglect of the elderly, but across all age ranges and in many specialties, including surgery, some of which was “grossly negligent”, according to the Royal College of Surgeons. Mid Staffs is currently one of many bust trusts, struggling on government handouts and shutting its emergency department overnight to save money and lives. It was always too small to be viable as a foundation trust; and the disastrous decision to push it down that route contributed to staff cut-backs that made the hospital so dangerous, and breed a culture of denial, demotivation and desensitisation. Twenty-one years after the Eye broke the story of the Bristol scandal, child heart surgery still hasn’t been safely re-established in a better resourced unit. Bristol is in trouble again, with further allegations of avoidable deaths, harm and understaffing in its child heart surgery unit.

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are plenty of good examples of hospitals responding to the rates after staff concerns, and improving care as a result. So what happened in Mid Staffs?

Fix the data, not the problem

In April 2007, Mid Staffs’ HSMR was 127 — one of the highest in the country. The Labour government’s David Nicholson, the strategic health authority, primary care trusts and health regulators should all have known this. In addition, a series of more specific mortality alerts — incidents may not be exposed to greater than expected risk — were issued to Mid Staffs.

On 3 July 2007, the Dr Foster Unit at Imperial College London sent Martin Yeates, the Mid Staffs boss, a mortality alert for operations on the jejunal (small bowel). Over the next four months the unit issued three further mortality alerts concerning aortic, peripheral, and visceral artery aneurysms; peritonitis and intestinal abscess; and other circulatory disease. Copies of three of these mortality alerts went to the Healthcare Commission (now the Care Quality Commission).

Chris Turner, who worked in the emergency department at Stafford Hospital in October 2007, described it to the public inquiry as “an absolute disaster”. Staff were threatened almost daily that they would lose their jobs if they did not get a patient through the department within the four-hour target, he claimed. The result was “significant numbers of patients in distress and, as a department, we were immune to the sound of pain”. On 5 December 2007 a meeting was held between Monitor and Mid Staffs for its application for foundation status. Monitor was told: “Our HSMR is currently 101: we do not have a mortality!”

So how did Mid Staffs manage to fix its figures without fixing the problem of appalling care? The 101 figure turned out to be a screenshot of the only point in time when Mid Staffs death rate approached 100.

Dr Philip Coates, the trust’s clinical governance lead, told the inquiry that the party line was that there was a “coding problem” and also a “problem with the Dr Foster/Jarman methodology”. “Instead of acknowledging that patients may have been dying because the hospital was failing to identify what exactly was wrong with them, we tried to find a way to get the figure lower and we started taking the view that the only problem was a coding problem.”

In March 2007, the Department of Health under Nicholson had relaxed the rules on palliative care coding, meaning any patient who had an “incurable illness” could be given the palliative care code, rather than those genuinely at the end of life under a palliative care consultant. This had enabled a private coding company, CHKS, to go to Midway hospital in Kent and work wonders overnight by coding many patients as “expected to die” and therefore on the palliative care route. In one seven-day period the death rate at Mid Staffs had risen to 35 percent of deaths at Mid Staffs, making it the largest hospice in the UK but without any of the compassion. And the mortality ratio had gone down to a much “healthier” level.

Change the diagnosis

Another way to reduce mortality alerts is to change the diagnosis. Patients come in with a fractured hip, and the longer the delay in operating, the more likely they will die, often from pneumonia. But if they have the pneumonia longer than the fractured hip, their primary diagnosis can be recoded as the former, and the death attributed to the hip fracture mortality alerts.

Using this method, the number of people dying after fracturing their femur at Mid Staffs fell from 101 to 0.9 percent, even though the number of people dying didn’t change. This entirely legal recoding was overseen at Mid Staffs by Texan coder Sandra Haynes Kirkbright (pictured). She had a philosophy degree and had learned how to “code” patients in the American insurance system of care.

Haynes Kirkbright recalls meeting HSMR guru Brian Jarman. “I said: ‘I think you should see a change in the HSMR’; and he said: ‘Coding can’t change the HSMR. I went: ‘OK it can’t’. But it totally can.”

By 2009, a patient with a hip fracture was seemingly five times less likely to die if admitted to Mid Staffs than to the average English hospital. But the Mid Staffs was seemingly one of the five “most improved” trusts for HSMR reduction in the country. And it might have got away with it, had it not been for the pesky Healthcare Commission.

‘All that is wrong with NHS management’

The belated Healthcare Commission investigation, which reported in 2009, was triggered by complaints from Julie Bailey and Care the NHS, and helped by local journalist Shaun Lintern.

It was led by fearless investigator Heather Wood, whom the Care Quality Commission later attempted to gag. Wood wrote in the British Medical Journal (BMJ): “Wood describes Mid Staffs as a symptom of a serious underlying illness in the NHS. “In all the investigations involving acute hospitals that I led on behalf of the Healthcare Commission, we found clear evidence of poor care on general wards, even when the focus was specifically on, for example, outbreaks of Clostridium difficile. Where some poor care may, arguably, stem from a fault line in the training of nurses, we found evidence that the poor care and failure to control and investigate the problem was not to the determination of managers to drive through financial restraint and achievement of targets.”

Wood also has the evidence that Mid Staffs was a symptom of a culture that would still be happening elsewhere, and believes that a change of culture in the NHS can only happen with a change of leadership.

BMJ joins the denial

The BMJ has recently printed some excellent analysis of Mid Staffs – but at the time it misjudged events.

On the day the Healthcare Commission report finally exposed Mid Staffs in 2009, for example, the BMJ chose to publish a paper from Birmingham University questioning the validity of using death rates to identify poor quality care, by authors who were already known to be deeply sceptical about them.

Prof Jarman, of Imperial College, has no competing interest the BMJ. He has recently printed some excellent analysis of Mid Staffs – but at the time it misjudged events.

This investigation “looked to me like a planned attempt at a spoiler”. Roger Davidson, head of the Healthcare Commission at the time, said in evidence to the public inquiry that the publication in the BMJ on the day the commission planned to publish an investigation into Mid Staffs, “looked to me like a planned attempt at a spoiler”.

This BMJ paper may have had the effect of not pursing Mid Staffs further into denial, but giving other NHS hospitals with high death rates an excuse for not investigating thoroughly.

Why Nicholson won’t go

Nicholson should be held to account over Mid Staffs, but he was carrying out the orders of his political masters. The political imperative was always to bury the bad news with the patients, silence dissent and deliver only good news to Downing Street.

As Sir Ian Kennedy observed in Bristol, too much power in the NHS is concentrated in the hands of too few people, which is both unhealthy and dangerous.

Nicholson is seen as indispensable both by those on the political left, who trust the former Communist Party member not to betray his roots and sell the NHS off to the market, and those on the right because he sticks to budget. His predecessor Sir Nigel Crisp resigned over a £2bn overspend (less than 1 percent of the NHS budget at the time). Nearly 1,200 patients have died unnecessarily in one hospital alone, and probably many thousands across the NHS, and yet to make Nicholson responsible would be to accept that the hugely disruptive market reforms he has enacted for Labour and the Coalition are also at fault.

Nicholson has had seven years in office and his management style simply isn’t suited to the compassionate, open, devolved, fear-free safety culture the NHS needs. There are plenty of gifted senior managers in the NHS (or from outside) more suited to the job. He recently disclosed that he has diabetes and is one of 700,000 NHS employees struggling with their weight. He should step down, get fit — and sit on a local Healthwatch board to learn how powerless the patient voice is. Then he should do what the politicians most fear: publish his memoirs.

Over the years Nicholson has enacted reforms to the NHS he clearly thought were blocks — but he has collected a very decent salary, pension, expenses and a knighthood for his troubles. Now the fixer has been found out, he could finally blow the lid on the damage constant political meddling does to the health service. But does he have the courage?