

MID STAFFS INQUIRY **Heather Wood**

Mid Staffs shows what's wrong with NHS management

The horrors at Stafford Hospital were failures of clinical care—but these were the symptoms, albeit deeply distressing, of a serious underlying illness. And that deep rooted pathology is the stranglehold that managers, many apparently devoid of an ethical code and certainly without a regulatory body, have on the NHS. Some of what follows has been expressed much more eloquently by Brian Jarman, director of the Dr Foster unit at Imperial College London,¹ in his recent editorial, “When managers rule.”²

The line promulgated by the chief executive of the NHS in his evidence to the Francis inquiry that Mid Staffordshire was a one-off is simply not sustainable. 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 infection were related to the determination of managers to drive through financial restraint and achievement of targets.

All the failings at Mid Staffs derived from the handing of control of decisions on priorities from the clinical professions to managers who were ultimately expected to follow the orders of senior managers. Those giving the orders often ignore or fail to understand the complexities of clinical care, the constraints on the NHS, and the impact of one policy on another component of care. Or they are aware but consider this as “collateral damage.” Those lower in the management hierarchy either have not understood the consequences of their actions or lacked the courage to stand their ground.

As the campaigning group Cure the NHS has commented, “The command and control style has crushed the culture of care in the NHS.” General management in the NHS has led over time to a control system where managers are

expected to implement initiatives without question and have not always acted in the best interests of patients. This is particularly evident in the acute hospital sector. NHS senior managers have over the past 20 years prioritised achievement of foundation trust status and of finance and waiting time targets over safe and compassionate care, particularly in emergency departments, assessment units, and general wards. Ministers and mandarins have tried to argue that both are achievable, but this has turned out to be a myth in many acute hospitals. Scandals such as Mid Staffs, Stoke Mandeville, and Maidstone and Tunbridge Wells show this clearly.

In the last two the pursuit of financial and waiting time targets directly affected the focus on infection control; concerned doctors and nurses were pilloried; patients were not adequately isolated; and cleaning was not thorough enough. In turn this led to serious outbreaks of *C difficile*, with corresponding deaths of patients. It can be argued that the decline in long waits for some patients was achieved at the expense of other patients' lives.

The original purpose of the edicts and initiatives from the Department of Health will generally be sold as benign (improved waiting times) or neutral (financial restrictions), but like all powerful drugs they may have serious side effects (I have adapted a quotation by David Haslam, a former adviser to the Health Commission). Politicians in power want to hear stories of success, not failure, and thus there is pressure to suppress critical evaluation and bad news. The culture of blame and fear and secrecy starts here.

NHS managers prepare reports with a view to presenting them in the best possible light to the higher levels of the NHS and the organisations' own boards. Reporting poor performance generally leads to negative consequences, so managers quickly learn to avoid it. Serious complaints and worrying incidents are concealed in meaningless histograms. Boards are told to focus on strategic



The balance of power must shift back to the clinicians

objectives and generally are not encouraged to challenge. They may even believe their own rhetoric. When serious concerns arise, or a scandal takes place, a senior manager will stand outside the hospital repeating a mantra about patient safety being the trust's top priority. Does anyone believe them?

Who knows what proportion of NHS managers in acute hospitals know or suspect that some of their actions may be harmful to patients but are indifferent or convince themselves that they have no choice. The achievement of certain centrally directed objectives is a “must do,” because most managers' performance related pay and career advancement depend on it. They may believe that they literally cannot afford to heed advice and warnings from clinicians, who become increasingly alienated. Managers who speak out often lose their posts and are silenced by a confidentiality agreement. Conversely, many managers who have presided over failures of care that often result from pushing through central directives move on to other highly paid jobs elsewhere in the NHS.

At Mid Staffs the combination of turning an already struggling hospital into a foundation trust and making excessive savings extremely quickly to achieve this, while pressing on to achieve targets, led to disastrous consequences for many patients. Again, the directives came from the top, and managers at all levels were complicit and unwilling to stand up and be counted. Taking £10m out of the budget in a year was a recipe for disaster. The board knew that the emergency department

had problems but chose to focus elsewhere, such as on how to market the trust effectively. Meanwhile, patients suffered and in some cases died. The trust executives, the board, the regulator Monitor, and the strategic health authority were all in denial about problems at the hospital and to varying extents resisted the Healthcare Commission's investigation and tried to have it ended early.

The prize for the team that exposed this scandal? We were disbanded by the Care Quality Commission, when it took over the Healthcare Commission's functions. The CQC's chief executive until her resignation was Cynthia Bower, whose most recent post had been chief executive of West Midlands SHA, with responsibility for Stafford Hospital.^{3,4} Readers must draw their own conclusions as to the stance of the health department on a forensic team that had perhaps exposed too many scandals for comfort.

Management in the NHS in too many instances has become mismanagement of the NHS. The NHS, though it needs to run efficiently, is not a business. It is about diagnosing, treating, and caring for patients in the best way. All its other functions should be subservient to that. Managers should help clinicians to achieve this aim; currently the system is set so that the opposite often happens. Recent changes do not deal with this: the top tier is the same old faces, the same culture prevails. The balance of power must tilt back to clinical staff. Patients' lives depend on it.

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- ▶ How the message from mortality figures was missed at Mid Staffs (*BMJ* 2013;346:f562); Did the government ignore criticisms of the NHS in the run up to the Mid Staffs scandal? (*BMJ* 2013;346:f652)
- ▶ For the latest news on the Francis inquiry go to bmj.com.