

# NZNO analysis of the Mid Staffordshire NHS Foundation Trust public inquiry

## Abstract

Reports of poor care and increased mortality rates at the Mid Staffordshire NHS Foundation Trust in the United Kingdom (UK) resulted in a large public inquiry that was completed in early 2012. The findings from the inquiry provide useful learning for nurses, NZNO and the wider health sector in New Zealand. This analysis covers the key findings and recommendations from the inquiry and the implications of these for nursing in New Zealand and NZNO.

## Background

The Mid Staffordshire NHS Foundation Trust is located just north of Birmingham in the United Kingdom. The Trust operates two hospitals at Stafford (301 beds) and Cannock (53 beds), employing approximately 3000 people and providing healthcare for approximately 320,000 people. Between 2005 and 2008, exceptionally poor standards of care at the Trust flourished, characterised by high mortality rates, reported breaches in standards of care, and serious patient complaints. There were numerous warning signs indicating that a problem existed during the 2005-2009 period including highly critical peer reviews and audits, whistleblowing by staff, and highly critical reviews by the Health Care Commission (HCC) but no action was taken. Two further reviews were commissioned by the Department of Health which gave rise to widespread public concern and loss of confidence in the Trust. Following these reviews, a first inquiry into individual cases of care was undertaken by Robert Francis QC to allow those most affected by poor care an opportunity to tell their stories. The period reviewed was January 2005 to March 2009.

This initial inquiry received complaints about care in many parts of Stafford Hospital and some from Cannock Chase Hospital. The complaints were predominantly focused on the A&E department, the emergency assessment unit and a number of other general wards. The majority of complaints were accounts related to basic nursing care as opposed to clinical errors leading to injury or death. The following areas were identified as particularly concerning:

- > Continence and bladder and bowel care
- > Safety
- > Personal and oral hygiene
- > Nutrition and hydration
- > Pressure area care
- > Cleanliness and infection control
- > Privacy and dignity
- > Record keeping
- > Diagnosis and treatment
- > Communication
- > Discharge management

In June 2010, a full public inquiry into the role of commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust was announced and it is the findings from this second public inquiry that are discussed here. As part of the second inquiry, Robert Francis heard from more than 160 witnesses over two years, and delivered 290 recommendations.

It is important to note that the gross breaches of patient care that occurred at Mid Staffordshire took place at the same time the Trust was working to achieve 'Foundation Trust' status. NHS Foundation Trusts are independent public benefit corporations. Although remaining part of the NHS, they are free from central Government control and are not subject to performance management by Strategic Health Authorities. They are free to retain any surpluses they generate and to borrow in order to support investment. In order to become a Foundation Trust, a NHS Trust must demonstrate (among other things) that they are legally constituted, have consulted with local people, are financially viable and sustainable, and are well governed (NHS, 2005). In addition, Mid Staffordshire was also focused on reaching national access targets and achieving financial balance.

The following outlines the key findings and recommendations from the inquiry. These are limited to those deemed particularly relevant to nursing. Page numbers identified below are relevant to the specific pages in the executive summary of the inquiry report unless otherwise noted. The executive summary of the inquiry can be found here: <http://www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>.

I have separated out the key findings and recommendations specific to nursing for the sake of this analysis and these can be found at the end of each respective section. While many of the recommendations made by the inquiry are relevant to overall system processes and structures, it is important to note that the contribution of nurses and the nursing profession to the situation at Mid Staffordshire was significant and an entire chapter of the inquiry report is dedicated to the findings in relation to nursing. I strongly recommend you read chapter 23. It can be found in volume 3 of the inquiry report: <http://www.midstaffpublicinquiry.com/sites/default/files/report/Volume%203.pdf>

Further information of interest can be found on the inquiry website including all three volumes of the report (<http://www.midstaffpublicinquiry.com/home>). Of particular interest may be the seminars on nursing which are available for viewing here: <http://www.midstaffpublicinquiry.com/inquiry-seminars/nursing>.

## The Inquiry

### Key findings

- > A culture of negativity existed within the organisation attributed to an engrained culture of tolerance of poor standards, a focus on finance and targets, denial of concerns, and isolation from practice elsewhere. The Trust's culture was one of self promotion rather than critical analysis and openness (p43-44).
- > Professionals were disengaged with the Trust. Consultants did not promote change, clinicians did not pursue management with concerns that they had, and the Trust lacked a sense of collective responsibility or engagement for ensuring quality care was delivered at every level (p44). The incident reporting system was onerous and reports were frequently not followed up on, meaning clinicians were disinclined to complete them (volume 1 p224-5).

- > There was no culture of listening to patients and there were inadequate processes for dealing with complaints and serious incidents. Regulatory requirements obliged the Trust to provide evidence that a complaints system was in place – not that the system was effective. The Trust was able to demonstrate a system existed and therefore demonstrate compliance with the regulatory requirements (volume 1 p223).
- > Staff and patient surveys continually gave signs of dissatisfaction with the way the Trust was run but no effective action was taken and the Board lacked awareness of the reality of care being provided to patients (p44). Interestingly a relationship between the number of 'dissatisfied' responses from patients in hospital surveys and mortality rates has been found: the greater the number of 'dissatisfied' responses (particularly to questions regarding communication), the greater the level of mortality will be (volume 1 p418). This was specifically studied at the Trust but no statistically proven association between poor patient and staff survey results and high mortality was found (NB there were a number of pertinent limitations to the study done). However, the inquiry suggests where a trust is performing poorly on all three measures then quality of care needs to be looked at closely (volume 1 p454).
- > There was poor governance. The Board failed to understand its accountability or governance structure and did not accept the importance of clinical governance sufficiently well to result in a functioning system (p44).
- > There was a lack of focus on standard of service. Leadership focused on financial issues at the cost of quality of service delivery. The economies imposed by the Trust Board had a profound effect on the organisation's ability to deliver a safe and effective service (p44) – the Board was attempting to make £1.1million projected savings in staff reductions (a reduction of 166.8WTE), £3.2million savings in 'other staffing efficiencies', £400,000 savings by adjusting staff mix, and £4.3million in staff wages (volume 1, p93).
- > The Trust prioritised its finances and Foundation Trust application over its quality of care and failed to put patients at the centre of its work (p44). There was a mismatch between resources allocated and the needs of the services to be delivered (p44-45).
- > The voice of the local community was absent. Despite patient surveys that contained disturbing indicators, systems to ensure effective engagement and participation by the local community in patient care were inadequate, and attempts to improve them failed. The inquiry notes that although there are a wide range of routes through which patients and the public can feed comments into health services and hold them to account, in Stafford these were largely ineffective (p46). Attempts to engage locals effectively as required by a Foundation Trust failed unequivocally.
- > General practitioners only expressed concern about the quality of care after the announcement of one of the earlier investigations and when they were specifically asked. The inquiry notes that a GP's duty to a patient does not end on referral to hospital (p47).
- > A number of authorities including the local Primary Care Trust (PCT), Strategic Health Authorities (SHAs), the Department of Health, Monitor (the organisation that assesses NHS Trusts for Foundation Trust status), the Health Protection Agency, the Health and Safety Executive, the National Patient Safety Agency, and the

Healthcare Commission (the first organisation to identify serious cause for concern, mandated to assess, review, regulate and investigate the quality of health care in the UK, abolished in 2009, and now known as the Care Quality Commission (CQC)), are all identified in the inquiry as having a role in ensuring safety and quality but:

- either failed to uncover issues; or
  - failed to communicate their concerns to each other;
  - failed to give priority to ensuring patient safety and quality standards were being observed at Stafford;
  - lacked strong quality processes in order to be able to monitor quality (volume 1, pp606-7);
  - each lacked a specific role to be able to identify the potential effects of cost savings and staff cuts on patient safety and quality e.g. the HCC had little financial expertise and Monitor had little clinical resource; and
  - even when deficiencies were identified, those that could, still failed to act to address the issues (partially limited by the contractual arrangements that existed – the two mechanisms available were to close services or limit funding until the issues were addressed neither of which would have addressed the concerns [volume 1, p669]).
- (pp49-56)

- > Generic standards established by the government and not by the regulator inhibited engagement with the standards by those working in the system (p54).
- > The system of education and oversight of medical training failed to detect any concerns about the Trust with only superficial attention to the standards being observed at the hospital. Complaints of bullying by staff toward trainees were not followed up or investigated (p59).
- > There was a disconnect between the policy decisions being made at the Department of Health and their practical implementation – structural reorganisations were not given sufficient time to succeed before the next wave of reorganisation occurred and there appeared to be a lack of a sufficient unifying theme and direction with regard to patient safety (p62). The Department of Health failed to recognise the impact that the structural reorganisations imposed upon trusts, PCTs and SHAs were having on quality care and patient safety (p62). The inquiry found that:
  - effective methods of policing national standards of care had not been achieved;
  - quality was not at the core of Department of Health policy – particularly policy regarding financial rebalance;
  - there should be senior clinical involvement in all decisions which may impact on patient safety and wellbeing;
  - Department of Health officials are too remote from the reality of the services they oversee – patients must come first;
  - well-intentioned decisions and directives arising from the Department of Health have been interpreted further down the hierarchy as bullying.

(p63-64)
- > Distrust in existing coding systems and quality of mortality data meant that little faith was placed in the reports of high mortality rates at the Trust. The high rate of mortality was concluded as being due to poor coding and not due to poor patient care (volume 1 p411-412). The inquiry notes that although there had been no malicious manipulation of data or coding at the Trust, it is important that regular

audits of data submitted by trusts is undertaken and that statistical analysis processes remain transparent (volume 1 p475-6).

## Key findings specific to nursing

- > There was inadequate risk assessment of staff reduction. There was an unacceptable delay in addressing the issue of shortage of skilled nursing staff. The inquiry believes this was due to the priority given by the Board to ensuring the Trust's books were in order for the Foundation Trust application. This resulted in an inadequate level of nursing staff and an apparently healthier financial position for the Trust. The inquiry notes that '...it [was] remarkable how little attention was paid to the potential impact of proposed savings on quality and safety' (p44). It is useful to note that the Director of Nursing was relatively inexperienced and inherited both an inadequate infrastructure to support her work and a poor skill mix when taking up the position in 2006. Although the Director of Nursing identified a lack of registered nurses as a concern and implemented a skill mix review, the time it took her to do this was criticised by the inquiry, as was the fact that she failed to draw her concerns to the Board's attention in an effective manner (volume 1, pp102-103, p223). The skill mix review recommended that the mix change from 40:60 skilled nurses/unskilled support workers to 60:40 skilled/unskilled (volume 1 p212). In addition, it took from 2008 to 2011 to implement appropriate staffing levels (volume 1, p214). It is unclear what supervision or support the Director of Nursing received from within or external to the organisation.
- > Nursing standards and performance were inadequate on some wards. This was due to poor leadership and staffing policies resulting in declining professionalism and a tolerance of poor standards. Some thought the nursing staff were stagnating and 'just wanting to do their day job' (Volume 1, p172). The inquiry notes that staff did report many of the incidents that occurred because of short staffing, and that poor morale was identified in staff surveys, however, staff received only ineffective representation of their concerns from the RCN (p44).
- > The RCN was ineffective both as a professional representative organisation and as a trade union. Little was done to uphold professional standards among nursing staff or to address concerns and problems faced by its members (p61). A primary reason for this was the lack of effective representation from elected officers on site and limited support from RCN officials at a regional and national level. The inquiry comments: 'The evidence reviewed in this report suggests that the RCN has not been heard as might have been expected in pursuing professional concerns about the standard of care. It appears there is a concerning potential for conflict between the RCN's professional role of promoting high quality standards in nursing, and its union role of negotiating terms and conditions and defending members' material and other narrow interests' (p62).
- > The potential for inconsistent outcomes where health practitioners are disciplined by differing professional bodies (in this case the General Medical Council and Nursing and Midwifery Council) with differing codes of conducts and sanctions. The complex and time consuming process is likely to dissuade the public and professionals from making complaints (p58).

## Key recommendations arising from the inquiry

- > The patient must be first in everything that is done;
- > there must be no tolerance of substandard care;
- > frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations (p66);
- > a set of fundamental standards must be developed, policed by a single regulator – the CQC – and set out in a manner that can be understood and accepted by providers, patients and the public. These standards should be the subject of extensive consultation to ensure patients, doctors and nurses have full confidence in them (p68);
- > any service or part of a service that does not fulfil the relevant fundamental standards should not be permitted to continue and the CQC as regulator should have the ability to take immediate protective steps in the interests of patient safety if it has concerns (p69);
- > non compliance with a fundamental standard leading to death or serious harm of a patient should be capable of being prosecuted as a criminal offence, unless the provider or individual concerned can show that it was not reasonably practical to avoid this (p69).
- > boards of directors should be liable to disqualification from the role unless they are fit and proper persons for it – the test for fitness should include a requirement to comply with a prescribed code of conduct (p70-71);
- > supportive agencies should be required to share their concerns regarding an agency with commissioners and regulators (p70);
- > a uniform process of complaints should be applied. Complaints should be easy to make and any expression of concern by a patient should be treated as a complaint unless patient permission is refused. Each clinician should facilitate access to the complaints system and facilitate a quick resolution where possible (p72);
- > staff must be supported to file incident reports and receive timely feedback on these (volume 1 p243).
- > learning from complaints must be effectively identified, disseminated and implemented (p72);
- > commissioners of services must be appropriately resourced to enable proper scrutiny of providers (p73);
- > students should not be placed in establishments that do not comply with the fundamental standards (p74);
- > there must be real involvement of patients and the public in all that is done (p74). Providers need to review unnecessary restrictions on visiting hours. The inquiry recommends visiting hours should be as open to visitors as would be a patient's home (subject to health requirements) (p75);
- > openness, transparency and candour must be evident throughout the system (p75);  
A statutory obligation should be imposed on:
  - healthcare providers, registered medical and nursing practitioners to observe the duty of candour;
  - directors of health care organisations to be truthful in any information given to a commissioner or regulator;
- > peer review must become part of the delivery and monitoring of any service or activity;

- > all healthcare support workers (HCAs, caregivers etc) should be registered. No unregistered person should be permitted to provide (for payment e.g. wages) direct physical care to patients under the care and treatment of a registered nurse or doctor (p77);
- > a uniform code of conduct for all healthcare support workers should be written and applied. All healthcare support workers should receive education and training in accordance with common national standards (p77);
- > a leadership college should be established to provide common professional training in management and leadership to potential senior staff. This could lead to an accreditation scheme enhancing eligibility for such roles (p78);
- > the General Medical Council and Nursing and Midwifery Council should have a clear policy stating the circumstances in which they should be informed of generic complaints. Both should aim to be more proactive in monitoring fitness to practise, launching their own investigations where appropriate (p79);
- > information must be available about the performance and outcomes of the service provided to enable patients to make treatment choices;
- > user friendly electronic patient record systems should be introduced and patients should be able to access, read and comment on these in real time (p81);
- > Trust Boards should provide quality accounts that outline their compliance with fundamental and enhanced standards (p81);
- > an independent Health and Social Care Information Centre should be set up for the collection, analysis, publication and oversight of health care information (p82);
- > before any major structural change to the health care system is accepted, an impact and risk assessment should be undertaken by the Department of Health and should be debated publicly (P82);
- > senior clinicians should be involved in all Department of Health decisions that may impact upon a patient's safety and well being (p82).

## **Key recommendations arising from the inquiry specific to nursing**

- > Commissioners of services should require the boards of providers to seek and record the views of its clinical and nursing directors of the impact on the fundamental standards of any proposed major change to clinical or nurse staffing arrangements or the provision of facilities (pp73-74);
- > there should be an increased focus on a culture of compassion and caring in nurse recruitment, training and education. This will require the establishment of national standards. A consistent standard of nursing education should be achieved throughout the country (p76);
- > nurse leadership should be enhanced by ensuring that ward nurse managers work in a supervisory capacity and are not office bound (p76);
- > there should be a responsible officer for nursing in each trust (p77);
- > consideration should be given by the Nursing and Midwifery Council to introducing an aptitude test to be taken by aspirant registered nurses prior to entering the profession to explore candidates aptitude toward caring, compassion and other necessary professional values (p77);

- > organisational standard procedures and practice should include evidence based tools for establishing service requirements for staffing and skill mix (volume 1 p243).
- > the special requirements of caring for the elderly should be recognised by consideration of introducing a new status: registered older person's nurse (p77);
- > the professional voice of nursing needs to be strengthened:
  - the RCN should consider how better to separate its trade union and professional representative functions;
  - a forum of nursing directors should be formed;
  - there should be at least one nurse on the executive boards of all healthcare organisations, including commissioners;
  - the advice of the nursing director should be obtained and recorded in relation to the impact on the quality of care and patient safety of any proposed major change in nurse staffing or facilities; (p77)
- > caring for patients:
  - a senior clinician or nurse should be identified for each patient, and patients and families should know who this person is;
  - no ward round should take place without the presence of the nurse in charge of the patients that are visited;
  - nurses should undertake regular ward rounds with patients to ensure regular interaction and engagement;
  - patients should never be discharged without knowledge of the care the patient will receive at their destination;
  - GPs must check on their patients after hospital treatment and assess whether the outcomes were satisfactory (pp79-80);
- > the Nursing and Midwifery Council must be equipped to look at systemic and organisational concerns rather than simply the practice or behaviour of an individual nurse.

## Implications for nursing in New Zealand

(References in this section come from chapter 23 of Volume 3 of the Inquiry Report unless otherwise stated.)

While it is inappropriate to make direct comparisons between what happened at Mid Staffordshire and the New Zealand context, there is some very useful learning to be taken from the inquiry. In particular, the prioritisation of improving fiscal status and achieving set government targets had a specific impact on the quality of service delivery at Mid Staffordshire. The economies imposed by the Board had a profound impact on the organisation's ability to deliver a safe and effective service. In terms of nursing, this impacted directly on staffing numbers, skill mix, and staff morale, resulting in poor patient care. Further, poor nursing leadership within the Trust further contributed to declining professionalism and poor patient care. The use of inexperienced staff, casual staff and caregivers to replace experienced staff added to the problem (various mentions, vol 1, p51-64, p144).

These factors underline the importance in the New Zealand context for strong nursing leadership at all levels within both public and private health sectors, close monitoring of outcomes of care within the context of current fiscal restraints and targets, and ensuring

that appropriate staffing levels and skill mix are maintained in all contexts and all areas of the health sector. There are a number of examples where fiscal restraint in the health sector is impacting on nurses and health outcomes in this country: Hutt Valley DHB has removed funding for any professional development for nurses outside of the DHB (e.g. conference attendance) until budget goals are met; and Matheson (2013) has found that economic constraint has resulted in inequitable access to primary care and a growth in unplanned admissions to hospital at Capital and Coast DHB. Matheson contributes this to a narrowing of focus on Ministry of Health Targets.

The work being undertaken by the Safe Staffing Unit should assist in identifying issues in New Zealand specific to nursing skill mix and in formulating strategies to address such issues – robust evaluation of the outcomes of the care capacity and demand management model developed by the Safe Staffing Unit is essential – however peripheral funding cuts and the impact of a focus on government targets such as in the examples given may not be captured by the Unit and further steps will need to be taken to capture this information on a national basis. In addition, the metrics developed by the Safe Staffing Unit should be rolled out to all public and private sector settings and further work should be done on developing metrics for the primary health and aged care settings.

New Zealand research clearly demonstrates that the reorganisation of the nursing workforce and in particular dismantling nursing leadership structures in the 1990 to 1996 period resulted in substantial increases in negative clinical outcome rates (with statistically significant increases in the rates for central nervous system complications, decubitus ulcers, sepsis, urinary tract infections, physiological and metabolic derangement, pulmonary failure, and wound infections) (McCloskey & Diers, 2005). The Stent Report into Canterbury Health Ltd (Stent, 1998) also identified a range of failings occurring as a result of reorganisation of nursing and dismantling of nursing leadership. These lessons must be heeded.

What is concerning is that despite the numerous organisations that had a role in monitoring care quality at the Trust, none were able to see the larger picture of what was going on in terms of patient care. It was due to the persistence of a small group of patients and their families that investigations were eventually held. Despite the existence in New Zealand of the Health and Disability Commission, the Health Quality and Safety Commission, ACC, the Ministry of Health, individual DHB quality structures, and the various peer review mechanisms that exist within medicine, there is no guarantee that a similar case could not happen here – in particular in light of the inquiry findings that staff were pressured to lie in their notes regarding achieving targets (p1503), and whistle blowers were bullied and ostracised (p1505). While New Zealand does have relatively robust systems, it remains important that New Zealand takes on board the lessons learned from this inquiry and analyses its own quality systems.

The inquiry recommends the development and application of fundamental standards of care (the inquiry also provides recommendations around enhanced standards of care) as a means of preventing a similar situation from occurring again. This may be one way of ensuring the Mid Staffordshire situation does not occur in New Zealand, however previous attempts at implementing, for example, standards of aged care have been considered too costly and a set of voluntary indicators have been put in place instead. Despite the indicators, concerns regarding standards of care in the aged care sector persist (see for example Health and Disability Commission investigations into individual cases available on: [www.hdc.org.nz](http://www.hdc.org.nz)). Making these indicators compulsory standards may be a starting point. The nursing profession already has established standards of practice (NZNO, 2012), education (Nursing Council of New Zealand, 2010), competencies for practice (Nursing Council of New Zealand, 2012; 2008; 2007), a code of conduct (Nursing Council of New Zealand, 2012a), a code of ethics (NZNO, 2010), and effective regulatory processes for managing complaints against individual nurses.

Regulated nurses are also required to complete 60 hours of professional development and 450 hours of practice in the previous three in order to retain their annual practicing certificate and may be audited at any time. This is different from the UK where currently there are no requirements for audit.

Based on the findings from the inquiry, addressing the culture of a workplace appears to be the fundamental requirement in ensuring individuals feel able to provide care to an appropriate standard and is likely to provide the most effective approach to ensuring the Mid Staffordshire situation could not occur in New Zealand. The inquiry team undertook visits to hospitals where effective nursing structures were in place and identifies a range of common characteristics (p1518) that are very similar to Magnet Hospital principles (<http://www.nursecredentialing.org/ForcesofMagnetism.aspx>).

While New Zealand had one hospital credentialed under the Magnet Hospital system several years ago, the costs of continuing credentialing were seen as unacceptable. However, although further research is required, preliminary NZNO data indicated that this hospital may have been demonstrating improved outcomes among staffing levels and staff morale during the period of time that it was credentialed. The inquiry notes the importance of effective nursing leadership at all levels as a means of addressing issues of culture and care (pp1518-1521) and New Zealand must ensure that leadership training programmes in this country cover the research relevant to Magnet Hospital principles along with the practical application of this type of system as one means of addressing issues of culture and care. The research supporting patient outcomes in Magnet Hospitals is largely unequivocal (<http://www.nursecredentialing.org/Magnet/ResourceCenters/MagnetResearch/MagnetReferences.html>).

Of particular interest to nursing was the call for health support workers (caregivers/health care assistants) to be regulated. Although many senior nursing leaders in the UK are opposed to this (pp1530-1531), the RCN supports it and the inquiry suggests a minimal register that records a unique identifier, a registered address, current and past employers, reasons for termination of previous employments, and any observations on those reasons by the registrant (p1537). At present, if there are issues associated with the care provided by a health support worker and they are dismissed, there is nothing to stop them obtaining employment at a different facility down the road – this is the same situation in New Zealand and registration is seen as one way of mitigating this issue.

A further concern identified by the inquiry was that many of the complaints made regarding 'nursing' care were actually in regards to care provided by health support workers not nurses. The inquiry suggests not only regulating health support workers but also requiring them to wear a nationally consistent uniform, be named as 'nursing assistants', and be required to undertake mandatory national training. The reinstatement of the enrolled nurse scope of practice on the New Zealand register is one way in which some of the issues associated with unregulated support workers have been addressed in this country, however, some DHBs and other providers – particularly in the aged care sector – continue to employ the same historical skill mix that they employed when the resident health, disability and social complexity was at a lower level and the length of stay was longer. They employ health care assistants rather than enrolled nurses (ENs) due to the cost of employing a regulated worker, when an enriched skill mix is actually required. If there is anything to be taken from the UK experience, then it is that there is a risk to patient outcomes if unregulated workers continue to provide basic care without appropriate education and supervision and within a culture of negativity. Research into the New Zealand skill mix context and patient outcomes is urgently required to identify the most appropriate skill mix model for improving patient outcomes in the New Zealand context.

The inquiry has also recommended that the UK Nursing and Midwifery Council be mandated to undertake systemic investigations into issues that may impact on fitness to practice. The Nursing Council of New Zealand is also not mandated to undertake systemic investigations, nor to launch investigations where broader issues are apparent. This is an area that could be considered for implementation as a further safety and quality mechanism within the health sector. For example, where Nursing Council is made aware of bullying within an organisation through a competence notification, currently no formal action can be taken by Nursing Council in relation to the institutional factors that may be contributing to this. The ability to undertake a broader investigation may serve to improve the workplace environment and subsequently patient care. There is clear evidence that a positive working environment (characterized by strong nursing foundations for quality of care, strong nurse manager leadership, ability and support, and collegial nurse/physician relationships) is conducive to improved patient outcomes (Aiken, Clarke, Sloane, Lake & Cheney, 2008).

Differing and complex processes potentially leading to differing outcomes for medical practitioners and nurses going through disciplinary proceedings was seen as likely to dissuade the public and health professionals alike from making a complaint. It may be useful for further work to be undertaken to ensure consistent outcomes from similar cases considered by the Health Practitioners Disciplinary Tribunal to ensure that the process remains transparent, robust and easy to use.

## Findings of particular relevance for NZNO

The inquiry heard from a number of witnesses who believed that the effectiveness of the Royal College of Nurses (RCN) as an authoritative professional voice promoting high quality standards in nursing was hindered by a perception of a conflict of interest with its other role as a trade union (p1522). While NZNO is similarly a registered union and professional body, there are differences between the two organisations that are likely to mitigate some of the risks outlined in the inquiry (these differences are outlined below). The inquiry found that:

- > although nursing staff persistently reported staff shortages, these shortages were not addressed either by the Trust or by the RCN;
- > the RCN regional representative (equivalent to a NZNO organiser) was found to represent both the complainant who raised issues about patient care and those being complained against simultaneously (see volume 1 pp107-111 for further information on this);
- > there were insufficient staff representatives for the number of members at Mid Staffordshire;
- > there was a lack of attendance at union meetings;
- > the one RCN staff convener that did exist was in a managerial role and claimed she was unaware of the volume of incident reports regarding staffing levels (pp1506-1507); and
- > the suicide of a young nurse apparently as a result of bullying was not followed up (p1511).

The RCN came in for particularly damning comment from the inquiry with identification of a lack of action taken in regard to promoting excellence in nursing and that as a body purporting to represent the professional interests of nursing, this should have been at the forefront (p1523). The inquiry noted:

*The inherent conflict between the representation of the interests of nurses as employees and the representation of their interests as a profession is*

*capable of diminishing the authority with which the RCN's views are received in relation to the standards of care capable of being provided by its members (p1523).*

As noted above, the inquiry recommends that the professional voice of nursing needs to be strengthened and in particular recommendation 201 states that:

*The Royal College of Nursing should consider whether it should formally divide its "Royal College" functions and its employee representative/trade union functions between two bodies rather than behind internal "Chinese walls" (p1542).*

The inquiry also recommends (recommendation 202) that recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions meet regularly to review the adequacy of this arrangement.

The RCN has commented that it will consider the findings of the inquiry carefully and that it supports the regulation of health care workers, establishment of fundamental standards, the importance of reporting poor care, and support for whistleblowers ([http://www.rcn.org.uk/newsevents/news/article/uk/rcn\\_responds\\_to\\_francis\\_inquiry](http://www.rcn.org.uk/newsevents/news/article/uk/rcn_responds_to_francis_inquiry)). RCN have also published a frequently asked questions page that provides further information for members regarding the inquiry. They note that splitting the union and professional arms of the organisation has been discussed openly with members as recently as 2012. Members indicated that they considered RCN to be a stronger organisation with the two elements combined. However, they note that they will consider the recommendations of the inquiry and discuss again with members (<http://thisisnursing.rcn.org.uk/pages/qa-for-members>).

## **Points for consideration and learning by NZNO based on the findings of the Inquiry:**

NZNO has a substantially different approach to organising work than the RCN. This approach mitigates many of the risks outlined in the inquiry. In the UK, RCN officers must be registered nurses and represent members both industrially and professionally, meaning the boundaries between these two aspects of work can become blurred. At NZNO, this role has been split with organisers (who may or may not be nurses and often hold other qualifications e.g. law degrees) taking on the industrial work of the organisation, and professional nursing advisers (who must be registered nurses) taking on the professional elements. There are comparatively greater numbers of organisers per member in NZNO than there are officers per member in the UK – this is because in the UK, the workplace delegate role is a paid position and delegates provide a much higher level of representation than in New Zealand where NZNO organisers take on the representative role not NZNO workplace delegates. NZNO workplace delegates act as the first port of call for members who need support but the organiser will take on any complex issues where a member needs representation. NZNO aims for a density of one workplace delegate per 10 members.

NZNO has very clear policies regarding conflict of interest. NZNO does not represent members who are managers in cases of conflict with an employee; instead, NZNO refers a manager to seek representation through their employer. Where two members are involved in conflict that does not directly involve a manager, NZNO will represent both members but use separate processes for each – this may mean seeking

independent representation outside of NZNO for legal matters (NZNO covers the costs of this). NZNO will represent nurse managers if there is an individual issue.

When working with nurses who need representation, reflection on practice is encouraged. This is frequently evidenced in performance improvement plans when these are the agreed outcome. NZNO also take the stand that despite the potential outcome being loss of job/s, a quality and safe service is advocated as the bottom line.

The relationships that exist between NZNO and employers in this country are also very different and much more structured than in the UK – particularly relationships with DHBs which would be the equivalent of the Mid Staffordshire Trust. This ensures that issues such as those that arose at Mid Staffordshire are brought to the attention of employers in a structured and timely manner. These structures include:

- > A healthy workplaces agreement embedded within the DHB Multi-employer Collective Agreement (MECA) that outlines the seven elements of a healthy workplace, and a joint commitment by DHBs and NZNO that these elements shall be evident in workplaces (the seven elements include a commitment to safe staffing levels, appropriate skill mix and effective measurement of these, and a safe workplace culture).
- > A mechanism that allows any party to the MECA to raise issues that they believe are not being addressed – the Bipartite Relationship Framework.
- > Oversight of implementation of the provisions of the MECA by a National Bipartite Action Group (BAG).
- > A national delegates committee that has regular communication within and external DHBs to raise awareness of issues within the sector.
- > Regular CEO meetings with the regulator, chief nurse, director general of health and minister of health to which unresolved concerns can be elevated.

Amalgamation of safe staffing principles into the MECA for DHBs provides a legal commitment by all parties to providing quality of care. However, smaller workplaces that are non-unionised or have low union-density – for example many smaller residential and aged care facilities – face greater risks for poor quality care given the lack of mechanisms available to staff for raising, managing and monitoring concerns. While indicators for safe aged-care and dementia-care for consumers assist providers to provide quality care, these indicators are not required standards. The Ministry of Health's Health of Older Persons group used to hold meetings between all stakeholders monthly and was an effective mechanism for dealing with arising issues in the sector. However this has been disestablished and no mechanism has been put in place to replace it. Auditing processes in aged care do provide a quality mechanism, and some DHBs are being proactive in placing managers into facilities that are having difficulties; however NZNO remains concerned about rostering practices.

NZNO also remains concerned that when delegates and/or members show courageous leadership on issues such as bullying in an hostile environment, they can be frustrated by inaction from workplace leaders (often because leaders are uncertain of how to respond apart from a process reply e.g. an acknowledgement). Practically this reduces morale and disempowers members and delegates.

In summary, the fundamental differences in structure between the RCN and NZNO make it unlikely that similar issues will occur in New Zealand. However, there are always opportunities to learn from situations such as that at Mid Staffordshire and to this end NZNO is committed to:

- > assessing the level of understanding by NZNO staff of the potential conflicts that could exist in the representation of members, and implementation of education if required;
- > ensuring members continue to be supported to report staff shortages through the incident reporting system at their place of work and considering encouraging members to send copies of these reports to workplace conveners for analysis by NZNO;
- > undertaking a national analysis of worksite membership and meeting attendance. Further work on recruitment and encouraging attendance at meetings to ensure strong representation may be required based on the findings of this analysis. If active engagement with the organisation is identified as an issue that needs addressing, it may be necessary to consider different approaches to recruitment and engagement from those currently utilised.
- > Continuing to consider ways to address bullying in the workplace and improve organisational culture.
- > Continuing to support leadership development for current and future nursing leaders.
- > Continuing to develop ways of ensuring that stakeholders understand that NZNO is both a professional and industrial organisation and represents the views of members in both these areas. Currently the professional aspirations of nurses to improve patient outcomes are cemented in employment agreements and this approach ensures good outcomes for both nurses and patients. Stakeholders must be made aware that good patient outcomes are a result of good nursing care and that good nursing care can only occur in an environment where conditions of employment are conducive to this.

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### **Mission statement**

NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.

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