Borders NHS Board

MID STAFFORDSHIRE PUBLIC INQUIRY REPORT

Aim

The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on 6th February 2013. The inquiry looked into what have been described as "serious failings" during the period January 2005 to March 2009.

This paper is intended to:

1. provide a brief overview of the report, highlighting the key themes
2. summarise work underway in NHS Borders to assess the organisations position against the recommendations contained within the report and identify opportunities for improvement

Background

In 2009, Robert Francis, QC was commissioned by the Secretary of State for Health in England to chair a non statutory inquiry in respect of the care provided at Mid Staffordshire from January 2005 to March 2009. The remit of the inquiry was principally to provide "a voice to those who had suffered and to consider what had gone wrong". When published it contained "damning criticism" of the care provided. The report also raised issues in respect of the role of external organisations that had oversight of activities at Mid Staffordshire.

Following publication of the report of the first inquiry on 24th February 2010, the decision was made to set up of a second inquiry. The inquiry chaired by Robert Francis, QC commenced in June 2010.

Summary

The Inquiry focuses on the NHS in England and the arrangements for directly provided NHS care. Within the report it is recognised that arrangements elsewhere in the UK do vary. This does not mean that lessons and recommendations arising from this inquiry are not relevant to NHS Scotland.

The Report:

- identifies the failings in Mid Staffordshire NHS Trust
- considered evidence regarding handling of complaints and concerns from patients and patients relatives and carers
- considers issues in respect external monitoring bodies with commissioning, regulatory and supervisory roles
- looks at reasons why "warning signs", serious issues and problems failed to be identified and acted upon earlier

- identifies lessons learned
- makes 290 recommendations

The report levels criticism at the various commissioning, regulatory and supervising agencies. While recognising shared responsibility for the fact that "the system as a whole failed in its most essential duty", primary responsibility for the identified failings is considered to sit with Mid Staffordshire.

Indications that things were not right were there as early as 2007, but these were not acted upon. The process of application for Foundation Trust status, which the Mid Staffordshire pursued at this time, would be rigorous, but did not take into consideration the quality of patient care. The report questions, why the failings in patient care were not detected sooner, and identifies a number of partners and agencies that were in a position to raise concerns and take action, but did not.

Warning signs included:

- the Commission of Healthcare reduced the Mid Staffordshire star rating from 3 to 0 in 2004
- concerns arising from peer reviews in 2005 and 2006
- Healthcare Commission Review of children's services in 2006 stated "the Trust did not meet the requirements or reasonable expectations of patients and the public
- Auditors report for the period identified "deficiencies in the Trust's risk management and assurance systems" and "called into question the competence of senior mangers and leadership"
- Healthcare Commission annual patient and staff surveys identified Mid Staffordshire to be in the 20% worst performing in several areas
- an allegation regarding leadership in A&E was not resolved nor were issues made known to any external agency
- Royal College of Surgeons report in 2007 concluded that the operation and management of the surgical department was "dysfunctional"
- Savings in staff costs were being made despite identification of serious problems in delivery of a quality service and problems in compliance with minimum staffing levels.

The table of recommendations contained within the report are grouped under themes. Although a number of the recommendations, such as those relating to improvements in the Foundation Trust process and changes to the English regulatory systems, are specific to the NHS in England, the recommended changes to professional regulation and the Health and Safety Executive will affect NHS Scotland. Of the other recommendations, these can be divided into five categories and grouped as follows:

- Standards of Patient Care
    - focus on putting patients first
    - nurturing a common culture supported by standards that staff and patients understand
    - professionally endorsed standards that are enforced and monitored effectively by the regulators.
- Culture
    - sharing of openness, transparency and candour throughout the system to ensure concerns regarding safety and care are brought to light
    - statutory, contractual duty of candour be introduced

    - criminalisation of attempts to obstruct candour or to dishonestly make untruthful statements to regulators
- Nursing and provision of care
    - focus on nursing but recommends accountability for all who provide care to patients
    - improvement in care through changes in improvement in recruitment, education, training and support for all healthcare professionals
    - nurse revalidation
    - greater regulation of healthcare support workers
    - more ward time for nurse managers
    - named nurse at each shift for every patient
- Leadership
    - improved leadership with greater accountability for senior managers
    - common code of ethics, standards and conduct for senior board level leaders and mangers
- Data and information
    - data, information and intelligence obtained from a range of sources
    - collation and use of relevant data and information
    - improved systems for storing, using and sharing data, intelligence and information
    - use of data to identify areas requiring improvement and to support improvement work.

Recommendation

Clinical Governance and Quality will proactively engage with Clinical Boards, Directorates, Board Executive Team and Non-Executives to assess key themes and implications for NHS Borders. This will involve examining systems and processes to:

- ensure that robust measures and monitoring processes are employed in respect of delivery safe, caring and compassionate care across NHS Borders
- ensure that in any area where care is found not to meet required standards that improvement action plans are in place and being progressed
- identify how NHS Borders ensures the ongoing promotion of a culture that supports delivery of safe, effective and person centred care
- ensure a culture of openness, transparency and candour is promoted

Over the coming six weeks an initial gap analysis will be produced by Clinical Governance and Quality in partnership with Clinical Boards, Directorates, the Board Executive Team and Non-Executives. This will be shared with relevant groups and committees in order to prepare a final report for the Board in June 2013. The Healthcare Governance Steering Group has endorsed these recommendations.

The Board is asked to **note** the work underway to assess the NHS Borders position against the recommendations contained with the Francis Report and that a final report will be produced for the Board meeting in June 2013,

Policy/Strategy Implications	The content of the ongoing work outlined will be considered by the Healthcare Governance Group and implications for NHS Borders reported to the Clinical Executive Strategy Group prior to

	presentation to the NHS Board
Consultation	As above
Consultation with Professional Committees	As above
Risk Assessment	In compliance
Compliance with Board Policy requirements on Equality and Diversity	In compliance
Resource/Staffing Implications	Services and activities provided within agreed resource and staffing parameters

Approved by

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