1. Introduction

1.1. This report is the third published report on the standards of care at the Mid Staffordshire NHS Foundation Trust (Mid Staffs) in the period 2005-2008. It is the final report of the Public Inquiry chaired by Robert Francis QC. The timeline for the review process in its entirety is seen at fig 1.

1.2. The scope of the three reports is shown below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Author</th>
<th>Scope</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 09</td>
<td>Healthcare Commission</td>
<td>What happened at the Trust? What do the indicators mean?</td>
<td>Trust</td>
</tr>
<tr>
<td>February 2010</td>
<td>Robert Francis QC</td>
<td>What was the patient and family view on what happened? What was their experience of care? What should be done now? (See summary findings at appendix A)</td>
<td>Trust and local systems (PCT / SHA)</td>
</tr>
</tbody>
</table>
2. The Report

2.1. The scope of the second Francis Report was to look at the wider systems in operation, now and at the time and identify where those systems might have contributed to the failings identified. It has built on the findings of the first report and looks to provide lessons from the inquiry as to how future NHS bodies regulate and monitor quality and safety. It sought not to replicate the first inquiry but to look at how the failings can be

The report is a recommendation of the 2010 Francis report which looked at individual cases. This report examines at how the problems were able to happen, concentrating on the regulatory and commissioning as well as Board functions.

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2.3. It builds on the findings of the first inquiry and but is not a review of what was contained within the previous report unless new evidence was presented.

2.4. The inquiry received many requests to look at similar concerns in other Trusts - this was not done as it was felt that this could have developed into an endless review.

2.5. As with the previous report the findings are grouped into themes and linked to a series of recommendations for action. Many of the 290 recommendations relate to NHS governing and regulatory bodies as well as provider services.
3. **The Warning Signs**

3.1. It is worth noting that the report is clear about the early warning signs that were not given sufficient attention or priority. It was the lack of action in relation to these warning signs which led to the eventual intervention and the problems that followed. These warning signs were:

- Loss of star ratings
- Peer Review - including Cancer, PICU, and follow up reviews.
- HCC Reviews Auditors Reports Staff and Patient Surveys - not universally bad but containing areas of concern
- Whistle blowing - nurse raising concerns about the leadership in A&E
- Royal College of Surgeons Report in Jan 2007 - critical conclusions about operation and management of the Trust surgical department.
- The Trust financial Recovery Plan and associated staff cuts - no detailed scrutiny by SHA
- FT application – whilst the HCC were aware of problems at Mid Staffs and proceeding with an investigation, Monitor were not aware of the HCC concerns and action. Nor were the HCC aware of the pending FT application.

4. **Findings**

4.1. This report finds no one person or body responsible for the poor care standards but it is interesting on analysing the 2,000 page report in full to look at the use of particular words.

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Culture – 559        Safety – 1,294
Complaint – 1,178    Leadership 920
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4.2. These words give a clue as to the main findings which relate to the culture of NHS organisations, leadership, personal accountability, fundamental standards of behaviour and most importantly, above all else, the failure to put the patient at the centre of decisions.

4.3. The report puts forward it its Executive Summary some of the key findings grouped under themes. These include:

4.3.1. A **negative culture** – the Trust took assurance from good news only and downplayed the significance of data that suggested poor performance. There was a culture of ‘self-promotion’ and not one of critical analysis.

4.3.2. **Patients were not listened to** at any level, within the Trust or by the regulatory authorities they were approaching. They were not involved in decision making at any level – including the Department of Health.
4.3.3. There were inadequate Trust systems for dealing with complaints and incidents – themes were not addressed and the governance processes are described as “vestigial”.

4.3.4. **Lack of nursing standards** and poor performance on some wards – low staffing levels, poor leadership, problems with recruitment and training. Declining professionalism and decline in standards

4.3.5. Poor morale in response to **staff surveys**.

4.3.6. The report also supports the findings in the previous investigation that **finances and the FT application** took priority over patient care.

4.3.7. There is criticism of many of the supporting patient groups (**LINKS, CHC** etc) who failed to listen and represent their community.

4.3.8. There are a number of findings in relation to the local **PCT** and its ability to deliver the quality surveillance it was resourced to do.

4.3.9. The **SHA** comes in for similar criticism - significant quality concerns were not communicated as part of the FT process when they should have been.

> "the underlying reason for the failure of SaSSHA and the WMSHA to adequately seek out or address patient safety and quality concerns about service provision at the Trust, was a failure of the leadership to give sufficient explicit priority to the protection of patients and to ensuring that patient safety and quality standards were being observed there. In common with the system as a whole at the time, the focus was unduly directed at financial and organisational issues and an over reliance on assurances given by others, while losing sight of the central purpose of the service it was seeking to support."

*Report of the Mid Staffordshire Public Inquiry Executive Summary p51*

4.3.10. The report finds that neither the **Board, the PCT nor the SHA** recognised or acted upon the significant warning signs.

4.3.11. The report goes on to look at the role of the **HCC, latterly the Care Quality Commission (CQC), Monitor and the Department of Health**. All are criticised for looking to **reorganisation and restructure** instead of changing priorities when seeking to address problems. They are also noted as not involving or listening to clinical staff when significant strategic decisions were made or targets set.

4.3.12. **Standards** set were found to be overly bureaucratic and not separated into what is essential and what is desirable.

4.3.13. The **Deanery and Universities** are found to have not communicated concerns raised to them and allowed training to continue in an area where care standards were poor.
4.3.14. The Royal College of Nursing were found to have been ineffective in challenging standards of care and in supporting nursing staff to raise concerns.

5. Why was there a delay in identification of the problems?

5.1. In summary this is presented thus:

- Lack of insight
- Defensiveness
- External agency accountability not well defined
- Lack of sharing of information by external agencies
- Lack of openness and transparency by the Trust
- Regulatory gaps and reorganisation
- Process and system management coupled with performance management of targets the main measures of performance
- Lack of engagement with the public, patients and clinical staff
- Failing to place the patient at the centre.

6. Lessons Learned and Key Recommendations

6.1. The report recommends a change in culture at all levels with a “relentless focus on the patients’ interests and the obligation to keep patients safe and protected from substandard care”.

“To achieve this does not require radical reorganisation but re-emphasis of what is truly important:

- Emphasis on and commitment to common values throughout the system by all within it;
- Readily accessible fundamental standards and means of compliance;
- No tolerance of non-compliance and the rigorous policing of fundamental standards;
- Openness, transparency and candour in all the system’s business;
- Strong leadership in nursing and other professional values;
- Strong support for leadership roles;
- A level playing field for accountability;
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation.”

Report of the Mid Staffordshire Public Inquiry Executive Summary p66
6.2. The report recommends **common values (putting the patient first)**, and that this must be enshrined in the NHS constitution. Also enshrined in the constitution should be simplified standards some of which are ‘fundamental’ against which there should be a zero tolerance of breaches.

6.3. **Regulation should be simplified** and changes made to the FT application process in order that poor quality care cannot be tolerated.

6.4. Any **Director of a Trust** should be a fit and proper person for the role – those found not to be should be disqualified from holding any such post in any other NHS organisation.

6.5. **Monitoring of compliance with fundamental standards** should be policed by a single regulator (the CQC). Compliance should be measured using indicators developed by NICE with input from clinicians. This should include guidance on the assessment of staffing requirements for individual services. The Royal Colleges and other organisations should also input into these.

6.6. The CQC should have the ability to take immediate steps to protect patient safety.

6.7. The **NHSLA** should set more demanding levels for financial incentivisation and arrangements made to share information.

6.8. **Complaints** need to be listened to and responded to with demonstrable action. Any concern should be treated as a complaint regardless of source. Complaints regarding fundamental standards should be accessible to the CQC and other bodies.

6.9. Commissioners need to have redress where standards are not being met – these will most likely be in the form of financial penalty. They may also have powers of intervention. They will have the ability to set medium and long term goals with providers in respect of developmental standards.

> “Commissioners should, in their contracts, require the boards of providers to seek and record the views and advice 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.”

*Report of the Mid Staffordshire Public Inquiry Executive Summary p73*

6.10. The report recommends improvements on **openness, transparency and candour** in relation to when things go wrong and clinical outcomes with benchmarking data.

6.11. There is a detailed section on **caring, compassionate and considerate nursing**. (*Mid Staffordshire Independent Inquiry, Vol 3, Chap 23, p 1497*). The recommendations relate to ward based senior nursing staff being supervisory, but not office bound. It recognises that cultural and resource issues impacted on the staff allowing poor standards to be accepted as routine in some cases.

6.12. The report recommends the introduction of a **revalidation** system for nursing, the introduction of a **State Registered Nurse for Older People** and a **registration system for Health Care Support Workers**.
6.13. **Leadership** is an absolutely central theme throughout the report. There are recommendations relating to a Leadership College and code of conduct for Managers.

6.14. “Hospitals should review, with a view to reinstatement, the practice of identifying a consultant or senior clinician and nurse who is in charge of each patient’s care, so that patients and families are clear who is in overall charge of that care. Those persons in charge and responsible for a patient’s care should be directly responsible for assisting in the response to any complaints that may be lodged in relation to the quality of care that that patient has received.”

*Report of the Mid Staffordshire Public Inquiry Executive Summary p79*

6.15. There is a detailed section on **care standards** which suggests some changes to the management of care including the presence of a nurse on all ward rounds, ward managers being supervisory in capacity but not office bound, improvements to discharge arrangements, administration of medicine being overseen by the nurse in charge and a responsibility for GPs to report any concerns or themes.

6.16. Finally the report makes recommendations in respect of **information and Quality Accounts**. Unsurprisingly these ask more information in an understandable and accessible format with accompanying benchmark data.

7. **Conclusion**

7.1. The report refers on numerous occasions to the demands of finance, performance and governance control being a direct contributor to the cultural failings which allowed the care problems at Mid Staffs to emerge.

7.2. The 290 recommendations can be summed up thus:

- Put the patient at the centre, before finance, before performance, before governance
- Listen to what the patients say about their experience of care
- Listen to what families and carers say about their experience of care
- Listen to what staff say about their experience of caring
- Understand the organisational culture and how to change it if needed
- Supervise and support staff at all levels
- Don’t reorganise – examine priorities instead

A complete list of themes can be found at appendix B.

8. **Responses**

8.1. The Prime Minister has confirmed that the Government will publish a full response to the report in March 2013.

8.2. The CQC issued a statement on the day of publication stating they would bring forward some already planned changes. This will include the appointment of a Chief Inspector of Hospitals and a new inspection process. The full detail of this response is at appendix C.
9. **Next Steps**

9.1. The Trust needs to undertake a systematic review of the detail of all of the 290 recommendations. Those applicable need to be mapped against existing work streams and any gaps identified.

9.2. A detailed action plan with clear, measurable objectives, assigned responsibilities and action timescales needs to be produced and presented to the Board of Directors for agreement in May 2013.

9.3. CMFT to produce a response statement for display on the Trust website.

9.4. The Board of Directors are asked to approve these steps.
Summary Findings of the First Francis Report

The first inquiry heard harrowing personal stories from patients and patients' families about the appalling care received at the Trust. On many occasions, the accounts received related to basic elements of care and the quality of the patient experience. These included cases where:

- Patients were left in excrement in soiled bed clothes for lengthy periods;
- Assistance was not provided with feeding for patients who could not eat without help;
- Water was left out of reach;
- In spite of persistent requests for help, patients were not assisted in their toileting;
- Wards and toilet facilities were left in a filthy condition;
- Privacy and dignity, even in death, were denied;
- Triage in A&E was undertaken by untrained staff;
- Staff treated patients and those close to them with what appeared to be callous indifference.

The first inquiry report was published on 24 February 2010. It contained damning criticism of the care provided by the Trust, drawing out a number of conclusions, including:

- There was a lack of basic care across a number of wards and departments at the Trust;
- The culture at the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff; there was an atmosphere of fear of adverse repercussions; a high priority was placed on the achievement of targets; the consultant body largely dissociated itself from management; there was low morale amongst staff; there was a lack of openness and an acceptance of poor standards;
- Management thinking during the period under review was dominated by financial pressures and achieving FT status, to the detriment of quality of care;
- There was a management failure to remedy the deficiencies in staff and governance that had existed for a long time, including an absence of effective clinical governance;
- There was a lack of urgency in the Board’s approach to some problems, such as those in governance;
- Statistics and reports were preferred to patient experience data, with a focus on systems, not outcomes;
- There was a lack of internal and external transparency regarding the problems that existed at the Trust.

290 recommendations grouped thus:

- Accountability for implementation of the recommendations
- Putting the patient first Fundamental standards of behaviour
- A common culture made real throughout the system – an integrated hierarchy standards of service responsibility for, and effectiveness of, healthcare standards
- Responsibility for, and effectiveness of regulating healthcare systems governance – Monitors healthcare systems regulatory functions
- Responsibility for, and effectiveness of regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings
- Enhancement of the role of supportive agencies
- Effective complaints handling
- Commissioning for standards
- Performance management and strategic oversight
- Patient, public and local scrutiny
- Medical training and education Openness, transparency and candour
- Nursing Leadership
- Professional regulation of fitness to practise
- Caring for the elderly Information
- Coroners and inquests
- Department of Health leadership
6 February 2013

CQC Chief Executive David Behan said: “Robert Francis’s report is defining for everyone involved in healthcare. People were badly let down by the NHS and those responsible for healthcare regulation and supervision. Our thoughts are with the families who have suffered. This kind of long term failure must not happen again.

“We agree with Robert Francis that the NHS should maintain a positive patient-focused culture throughout.

“CQC’s purpose is to make sure hospitals provide patients with safe and acceptable standards of care, underpinned by an open culture, effective leadership and clinical engagement. The primary responsibility for delivering quality care lies with the leadership of hospitals, care professionals, clinical staff and those who commission the care.

“No system can guarantee that there will never be failings. Regulators and supervisory bodies must be much better at identifying and challenging poor care and in working together to improve people’s experiences of care. And boards, managers, care staff and commissioners must take responsibility. And we must all listen to patients.

“Today's statement by the prime minister sets clear objectives for CQC which strengthens our role as regulator. We will continue to operate as a single, unified regulator across health and social care.

“In his statement today the Prime Minister asked CQC to bring forward proposals to appoint a Chief Inspector of Hospitals. The appointment of a Chief Inspector of Hospitals will enable us to put a sharper focus on hospital care – really getting to grips with what’s most important to patients and their families. As the Prime Minster said, this will help to ensure hospitals are clean, safe and caring.

“The prime minister's statement, together with the recommendations of the Francis report, reinforces the changes we have set out recently.

“Our priority now is to develop and deliver these commitments in the light of the prime minister’s statement. We will begin to move towards a new approach in the way we regulate NHS hospitals from this summer.

• We are changing how we inspect hospitals. We will look more closely at how hospitals are run... (simply put, do the doctors talk to the managers, do board members talk to patients; how well do hospitals learn from mistakes and complaints ?). We will use more clinical experts in our inspection teams, (if it’s about nursing, we will take a nurse with us) and we will involve more members of the public with direct experience of hospital care - ‘experts by experience’ – in our inspections.

• We will look at how we can develop teams of specialist inspectors, who will work alongside clinical experts and people who use services.
Agenda Item 9.1

- We will listen much harder to what people who use services tell us about the reality of the care they receive. And we will work more closely with others and use a wider range of information and evidence in our assessment of quality and performance.
- We are changing our board and the way it works. We will build a transparent, well governed and effective organisation."

"We believe that Robert Francis's recommendations in relation to a positive patient culture apply across all health and social care and we also will consider appointing a Chief Inspector for Social Care."