Review of Mid Staffordshire NHS Foundation Trust Public Inquiry
(R. Francis February 2013)

1. Executive Summary

1.1 This report is intended to provide a high level briefing in relation to the Review of Mid Staffordshire NHS Foundation Trust Public Inquiry, (February 2013), the Governments response and proposes actions required by the North East Ambulance Service NHS Foundation Trust for wider consultation.

2. Introduction

2.1 Following the publication in 2010, of the first Francis report into the events at Mid Staffordshire NHS Foundation Trust, Robert Francis QC conducted a public inquiry and subsequently published the findings in February 2013. The report identifies how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address the trusts problems, even when the extent of the problems was known.

2.2 This briefing gives a high level précis of the main recommendations of the second report of Mid Staffordshire NHS Foundation Trust Public Inquiry and the Government's initial response. The reports should be read in full to comprehend the appalling failures of a health system and the recommendations examined in full to understand the implications and impact as a care provider and a Foundation Trust.

2.3 Like the first report it makes uncomfortable reading and clearly sets out the system's failure in one establishment. However, it is recognised that standards of care are falling below what should be expected in some organisations across the country; the Medical Director from NHS England has been asked to review a number of other NHS hospitals whose care appears to be below standard.

2.4 Sir David Nicholson's letter dated 6th February 2013 has asked the report be read, discussed, debated and for all to reflect on the findings. He urges organisations not to wait for guidance or the response to the report. Although there will be further communication on the how to take forward the recommendations from the report in the near future.

2.5 The Secretary of State has written to all Trust Chairs and is asking for internal staff events to share the report's findings and recommendations, and ask staff what they think and how to deliver high standards of care to every patient.

2.6 To date, the Board has reviewed and considered the report at the Board seminar held on 28th February 2013, as has the Quality Committee and the Governors attended a seminar on 3rd April 2013. Trade Union representatives have also considered the report at a meeting of the Trust's Joint Consultative Committee.

3. The scope of the inquiry

3.1 The scope of the inquiry was to build on the evidence of the first inquiry, and to examine the operation of commissioning organisations, supervisory and regulatory organisations and other agencies involved. The aim was to identify lessons to be learned for the future NHS, and to make recommendations to the Secretary of State for Health.

3.2 The findings of the first inquiry included concerns regarding a lack of basic standards of care (in some wards and departments), too high a priority on targets rather than patients and a management and Board focussed on financial targets. In addition, a focus on systems not outcomes, with statistics and reports preferred over patient experience, a trust culture not supportive of staff and an acceptance of poor standards of care and a lack of effective governance, internal and external transparency.

4. The Process

4.1 The Inquiry was undertaken within an agreed Terms of Reference, underpinned by the Inquiries Act 2005 and is structured around:

- warning signs that existed and could have revealed the issues earlier
- governance and culture
- roles of different organisations and agencies
- present and future

4.2 A total of 163 witnesses provided oral evidence, and 352 witness statements were taken. The word *'hindsight*' appeared 123 times in transcript and *'benefit of hindsight'* 378 times. The process culminated in the production of over 1 million pages of evidence resulting in 290 recommendations which primarily focus on securing a greater cohesion and culture across the system.

5. Summary of key Findings

a) Review responsibilities and accountabilities of Directors and Senior Managers
b) A lack of openness to criticism
c) A lack of consideration for patients
d) Defensiveness
e) Looking inwards and not outwards
f) Secrecy
g) Misplaced assumptions about the judgements and actions of others
h) An acceptance of poor standards
i) A failure to put the patient first in everything that is done

6. Key Recommendations

a) Governance and Trust Boards: Enhanced accountability at Board level for poor quality care
b) Monitor, and authorisation of Foundation Trusts: A single regulatory body covering all aspects, suggests CQC. Also suggests changes to the authorisation process – ensuring fitness for purpose/delivery of safe, sustainable appropriate quality care
c) New Fundamental and Enhanced standards of quality: Zero tolerance to sub-standard care, decommissioning of services that fail to meet fundamental quality standards, new criminal sanctions envisaged in event of serious harm or death of a patient due to poor quality care
d) Duty of Candour, Complaints and Clinical Risk: Enhancements to provision of information, inspections and monitoring. Triangulation of all sources of hard and soft intelligence

e) Workforce issues: Contractual duties around NHS Values and Constitution (putting the patient first), Fitness to practice procedures should not delay internal disciplinary procedures. Assessment of impact of proposed staffing reductions on quality of care and patient safety – specific duty of Nurse Director
f) Commissioning for Quality: Commissioners would have primary responsibility for quality, and would decide what services are needed and who should provide them, call time on services providing sub-standard care and have recourse to commission services from an alternative provider wherever possible
g) Role for the regulators: Clear role for national regulators in bringing about cultural change. Includes a number of recommendations for GMC and NMC.

7. Expectations from Francis II

a) How lessons learned might be applied to other parts of the health economy

b) All healthcare organisations should consider the findings and recommendations and decide how to apply them to their own areas of work
c) Each organisation should announce its progress against planned actions (no less than once a year)
d) DoH should publish collective progress
e) House of Commons Select Committee on Health should consider incorporating update on actions from those organisations responsible to Parliament.

7.1 The Inquiry was confined to Mid Staffs, but evidence emerged of other places where unhealthy cultures, poor leadership and an acceptance of poor standards of care are prevalent. The report calls for more transparency and real time information from the public and providers. It focuses on the weaknesses of the current complaints system, but states the real focus must be on preventing complaints occurring in the first place. The report recommends that the whole system must revolve around quality, stating that top-down management is no longer viable and makes specific recommendations in relation to the nursing and medical professions. The report also points out that trainees are invaluable eyes and ears in a hospital setting.

8. The Initial Government's Response to the Report of the Mid Staffordshire NHS Foundation Trust Inquiry.

8.1 The above response, 'Patients First and Foremost' was presented to Parliament by the Secretary of State for Health on 26th March 2013. It details key actions to ensure that patients are the '*first and foremost consideration of the system and everyone who works in it'* and to restore the NHS to its core values as outlined within the NHS constitution.

8.2 Each organisation is required to reflect upon behaviours and priorities and to learn from the events that occurred at Stafford Hospital. The response does not respond individually to the 290 recommendations within the Francis II report but is divided into five key areas designed to improve the care people receive from the NHS:

1. Preventing problems
2. Detecting problems quickly
3. Taking action promptly
4. Ensuring robust accountability
5. Ensuring staff are trained and motivated.

8.3 In order to support staff to bring about the required cultural change a revised NHS constitution was also published that is informed by the lessons from the Public Inquiry and makes clear to staff the importance of common values and focuses upon the fundamental value of '*working together for patients*'. Further amendments to the NHS Constitution are anticipated later in 2013 to respond in full to the Inquiry's recommendations.

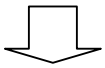
9. Considerations and actions for NEAS

9.1 Whilst it is important to acknowledge the work already undertaken by the North East Ambulance Service NHS Foundation Trust following the publication of the first Francis report (2010), the action plan in Appendix 1 details work in progress and proposes additional actions for the Trust to ensure learning from the Inquiry is maximised.

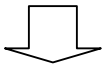
9.2 Furthermore, the findings and recommendations have been and still are considered in the development of our wider strategic plans and organisational objectives. The graphic below shows that by identifying and combining the work to be undertaken by the Trust in response to a variety of reports, strategies, priorities, etc. into an overarching high level action plan.

9.3 The action plan at Appendix A therefore aligns the actions required to address the recommendations of Francis II alongside responses to other significant programmes of work to avoid un-necessary duplication and to ensure appropriate prioritisation.

Francis II	Responding to Staff Survey Results	MaPSAF Results	Regional Investing in Behaviours Programme	Implementing Amendments to Agenda for Change	Trust priorities e.g. absence, wellbeing, etc.	Monitor Quality Assurance Framework	Improving Staff Engagement



Overarching Action Plan (see Appendix A)



Trust Governance Assurance Framework (see Appendix A – column 3)

10. Recommendations

10.1 The Board is asked to review and consider the report, seek any clarification and agree the proposed action plan and reporting arrangements outlined in Appendix 1.

10.2 Biannual reports on progress of key actions will be reported to the Board.

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Director of Clinical Care & Patient Safety

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References:

Patients First and Foremost
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

NHS Constitution (March 2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

NEAS Staff Survey 2012 results

North East SHA - Investing in Behaviours Programme

NEAS MaSAF results and response

Agenda for Change amendment – [A4C pay circular 2/2013]

NEAS Board report – Developing a Strategy for Employee Engagement – 31 January 2013

Appendix 1 – Action Plan

Prevent problems	Response In place OR In place/further dev needed OR New initiative	Assurance / Monitoring Arrangements	Francis II	Staff Survey	MaPSAF	Investing in Behaviours	A4C	Trust Priorities	Monitor Quality Assurance Framework	Staff Engagement
Compassionate Board focussed on quality										
- Board develop programme	In place	Trust Board	X		X	X		X	X	X
- Competency framework for Board members	In place	Trust Board	X		X	X		X	X	
- Quality performance review	In place	Trust Board	X		X	X		X	X	
- Governors development and engagement sessions	In place	Trust Board	X		X	X		X	X	X
Supporting staff to care										
- Valued based induction	In place	WEC	X			X		X		X
- Training & support	In place	WEC	X	X		X		X		X
- ***Performance review objective***	In place/further dev needed	WEC	X			X	X	X		X
Measuring culture										
- Staff survey	In place	WEC	X	X	X	X		X		X
- Quality walkarounds	In place	WEC/Trust Board	X	X	X	X		X		X
- Station visits	In place	WEC	X	X	X	X		X		X
- Micro surveys	In place/further dev needed	WEC	X	X	X	X		X		X
- Exit interview	In place	WEC	X	X	X	X		X		X
- ***Cultural indicators***	Development needed	WEC	X	X	X	X		x		X
Creating time to care and lead										
- ***Team leader recruitment***	In place/further dev needed	WEC/E Care SLM	X	X	X	X		X		X
- ***Team leader competency framework***	New initiative	WEC/E Care SLM	X	X	X	X		X		X
- ***Team leader development & support***	New initiative	WEC/E Care SLM	X	X	X	X		X		X
- ***Protected time arrangements***	In place/further dev needed	WEC/E Care SLM	X	X	X	X		X		X
Zero harm										
- ECLIPS	In place	QC/Board	X	X	X	X		X		X
- Quality Committee	In place	Trust Board	X	X	X	X		X		X

Detect problems quickly	Response In place OR In place/further dev needed OR New initiative	Assurance / Monitoring Arrangements	Francis II	Staff Survey	MaPSAF	Investing in Behaviours	A4C	Trust Priorities	Monitor Quality Assurance Framework	Staff Engagement
Ratings/AQI's										
- Monitor proposal	New initiative	QC/Trust Board	X							
- Respond to consultation	New initiative	QC/Trust Board	X							
- Continue monitoring and benchmarking and quality improvement of AQI	In place/further dev needed	QC/Trust Board	X							
Quality Review and Surveillance										
- Develop and embed Quality Review Group	In place/further dev needed	QC	X		X	X		X	X	
- ***Engage with Quality Surveillance Group***	New initiative	QC	X					X	X	
Transparency										
- Quality Report	In place	Trust Board	X		X	X		X	X	X
- Trust Annual Report	In place	Trust Board	X					X	X	X
- Governance transparency	In place	Trust Board	X					X	X	X
Quality and Risk Profiles										
- Continued reporting to Quality Committee and Gov & Risk Committee	In place	QC/Gov and Risk/Trust Board	X					X	X	
Duty of candour										
- ***Report learning on Trust website***	New initiative	ECLIPs/QC	X		X	X		X	X	X
- Continued reporting arrangements	In place	ECLIPs/QC	X		X	X		X	X	
- Prompt, honest and proactive response to errors	In place	ECLIPs/QC	X		X	X		X	X	X
Criminal Sanctions										
- ***Current criminal sanction for Board member apply***	In place/further dev needed	Trust Board	X			X		X	X	
- ***Monitor proposals to extend/enhance santions***	New initiative	Trust Board	X			X		X	X	
- ***Respond to consultations on proposals***	New initiative	Trust Board	X			X		X	X	
Whistleblowing										
- ***Re-enforce Trust arrangements***	In place/further dev needed	WEC/Trust Board	X	X	X	X		X	X	X
- ***Review compromise agreement clause***	In place/further dev needed	WEC/Trust Board	X					X	X	X
Engaging and involving patients										
- Incidents	In place	ECLIPs/QC	X		X	X		X	X	
- PALS	In place	ECLIPs/QC	X		X	X		X	X	
- Patient focus groups	In place	ECLIPs/QC	X		X	X		X	X	
- EDS	In place	ECLIPs/QC	X		X	X		X	X	

Detect problems quickly	Response In place OR In place/further dev needed OR New initiative	Assurance / Monitoring Arrangements	Francis II	Staff Survey	MaPSAF	Investing in Behaviours	A4C	Trust Priorities	Monitor Quality Assurance Framework	Staff Engagement
Patient and Staff feedback										
- Staff survey	In place	WEC	X		X	X		X	X	X
- ***Clinical team reporting***	In place	QC	X	X	X	X		X	X	X
- ***Net promoter score***	In place/further dev needed	ECLIPs/QC	X		X	X		X	X	X
Complaints										
- Continue robust and responsive system	In place	ECLIPs/QC	X		X	X		X	X	
- ***Maximise learning from complaints***	In place/further dev needed	ECLIPs/QC	X		X	X		X	X	X
Healthwatch										
- ***Implement strategic engagement plan***	New initiative	ECLIPs/QC	X		X	X		X	X	
- ***Establish mechanisms to share knowledge and raise issues***	New initiative	ECLIPs/QC	X		X	X		X	X	
Sharing Information										
- IPR	In place	Trust Board	X		X	X		X	X	X

Taking Action Promptly	Response In place OR In place/further dev needed OR New initiative	Assurance / Monitoring Arrangements	Francis II	Staff Survey	MaPSAF	Investing in Behaviours	A4C	Trust Priorities	Monitor Quality Assurance Framework	Staff Engagement
Fundamental standards - Monitor proposals - Consider implications for the Ambulance Service - Respond to consultation	 No immediate action No immediate action No immediate action	Gov and Risk/Trust Board	 X X X	 X					 X X X	 X
Time limited failure regime for quality and finance - Monitor proposals - Respond to consultation	 No immediate action No immediate action	BIF/Gov and Risk/Trust Board	 X X X						 X X X	
Foundation Trust status - Ensure compliance with license - Ensure compliance with Monitor Quality Governance Framework	 In place In place	Gov and Risk/Trust Board	 X X						 X X	

Ensuring Robust Accountability	Response In place OR In place/further dev needed OR New initiative	Assurance / Monitoring Arrangements	Francis II	Staff Survey	MaPSAF	Investing in Behaviours	A4C	Trust Priorities	Monitor Quality Assurance Framework	Staff Engagement
HSE to use criminal sanctions - ***Ensure Board/senior managers are aware***	New initiative		X							X
Faster and proactive professional regulation - Monitor proposals and respond to consultation - Implement any new regulation	No immediate action No immediate action									
Directors and senior leaders - ***Review job descriptions, terms & conditions*** - ***Objective setting and performance review***	In place/further dev needed In place/further dev needed	WEC WEC	X X	X X						X x
Barring system for Healthcare assistants - Not applicable to NEAS	No immediate action									
Clear responsibilities for tackling failure - Capability policy - Disciplinary policy	In place In place	WEC WEC	X X							

Ensure staff trained & motivated	Response In place OR In place/further dev needed OR New initiative	Assurance / Monitoring Arrangements	Francis II	Staff Survey	MaPSAF	Investing in Behaviours	A4C	Trust Priorities	Monitor Quality Assurance Framework	Staff Engagement
Treating staff well										
- ***Health, safety & wellbeing***	In place/further dev needed	WEC	X	X				X		X
- ***Rewards & recognition***	In place/further dev needed	WEC	X	X			X	X		X
- ***Work/life balance***	In place/further dev needed	WEC	X	X				X		X
- ***Equality & diversity***	In place/further dev needed	WEC	X	X				X		X
Staffing levels										
- ***Establishment control***	In place/further dev needed	WEC	X					X		
- ***Workforce planning***	In place/further dev needed	WEC	X					X		
- ***Workforce management***	In place/further dev needed	WEC	X	X				X		X
- ***Resource scheduling***	In place/further dev needed	WEC	X	X				X		X
Making time to care										
- ***Protected time***	In place/further dev needed	WEC	X	X				X		X
Rewarding high quality care										
- ***Recognition schemes***	In place/further dev needed	WEC	X	X		X	X	X		X
Listening to staff										
- ***Communication strategy***	In place/further dev needed	WEC		X						X
- ***Developing the "Employee voice"***	In place/further dev needed	WEC	X	X						X
- ***Trade union engagement and support***	In place/further dev needed	WEC								X
Recruitment and training										
- ***Values based recruitment***	In place/further dev needed	WEC	X	X				X		X
- ***Effective performance review & PDP system***	In place/further dev needed	WEC	X	X	X	X	X	X		X
Revalidation for nurses										
- Paramedic registration / CPD	In place	WEC	X					X		
- ***CPD for other NEAS employees***	In place/further dev needed	WEC	X					X		
Health and Care Support workers										
- ***Principles of patient care paramount for all NEAS workforce***	In place/further dev needed	WEC	X					X		X
Caring for older people										
- Safeguarding	In place	WEC	X							
- Specialist training	In place	WEC	X							
Attracting Professional and External Leaders to Senior Management Roles										
- ***Internal talent management and development***	In place/further dev needed	WEC	X							X
- ***Engagement in regional, national and international leadership programmes***	In place/further dev needed	WEC	X							X
- ***Network with world class organisations***	In place/further dev needed	WEC	X							X
Frontline experience for all staff										
- ***Principles of personal exposure to the patient experience for all NEAS workforce***	In place/further dev needed	WEC	X							X