

# Briefing

## Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry

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# Overview

This is the second inquiry chaired by Robert Francis QC into failings at the Mid Staffordshire NHS Foundation Trust. The first, published in 2010 revealed widespread and catastrophic failures of care, much of it involving older people. This second inquiry examines in more detail why it believes the failures happened, though stops short of identifying any individuals who were ultimately responsible.

It contains particular criticism of the performance of the board of governors, regulatory structures, and the maintenance of professional standards. Its key recommendations include making oversight of unsafe care a criminal offence; stricter rules around membership of senior hospital boards and management; and regulation of healthcare assistants.

## Introduction

The final report of the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust today sends a strong message across the NHS and beyond. It is vital that participants across the system do not view what happened at the hospital in isolation or regard it as a unique horror to be consigned to the history books.

While we must sincerely hope that the scale of tragedy is rare, many of the issues that we saw raised by the inquiry - older patients not provided with adequate nutrition and hydration, their personal hygiene not attended to, and not being treated with dignity and respect – are still today experienced all too often by older people in both health and social care settings.

Report after report has detailed shocking examples of how older people and their families have been let down when hospitals and care homes fail to deliver decent care or treat them with dignity.

We wholeheartedly agree with Robert Francis QC's observation that there is a need for real change in the culture for all who work in the NHS to ensure that the patient is put first. Compassion and empathy must be part of care at every level of decision making and in every situation. Evidence of poor care must never again be tolerated, dismissed or the views of patients and families ignored.

Today's report must be a watershed moment in this country where politicians and professionals once and for all take this opportunity to make the deep and lasting changes required. A 'sticking plaster solution' is not going to be acceptable and will certainly not be enough to reassure millions of older people and their families.

This will mean recognising the realities of the modern NHS. At any one time about 65 per cent of patients in hospital will be over the age of 65. Many of them will be frail, suffering from dementia and have complicated conditions. We need to ensure our hospitals are equipped to care for older people with skill and compassion.

We need to ensure all staff are well trained in caring for frail older people and empowered to deliver excellent care supported by senior managers. This also means listening to and working with patients and their families to make sure that care is right as part of a drive within the NHS for continual improvement.

Following the first report into Mid-Staffordshire NHS Foundation Trust, Age UK acted to set up the Dignity in Care Commission with the NHS Confederation and the Local Government Association. The Commission has since sought to understand why poor care persists and has put forward recommendations that provide a blueprint to help the NHS and care homes make the real and enduring changes needed to consistently deliver dignified and compassionate care.

Age UK will now call on the Government and all sections of the NHS to respond to the findings of the Francis Report by making fundamental changes to the way people are cared for throughout NHS services. This report must electrify the NHS to change its culture and make hospitals safe places for everyone. Care must always be provided to older people with compassion and empathy.

## Age UK interim response to recommendations

- The government will publish its full response in March 2013. It is vital the Prime Minister and Secretary of State for Health set out clearly how they will respond to the recommendations in the Francis report and deliver a comprehensive plan of action to transform culture and practice, as well as policy and systems, to ensure good care is delivered to every patient every time.
- The report is absolutely right to highlight the importance of culture change. At the root of the failure was a willingness by staff to tolerate appalling standards of care. The culture must change so that such care is seen as utterly unacceptable.
- We welcome the report's clear recognition of the importance of patient and public involvement in health care and their vital role in provider supervision and improvement. However, we should not underestimate the long way there is still to go to ensure the voices of patients, families and the public are set on a par with those of professionals and managers in the system.
- We agree that there must be much stronger accountability at the top of NHS providers. Governing and management boards should not be allowed to remain in place when patient safety and dignity has been compromised.
- We welcome the fact that the report so clearly identified the importance of having a workforce that both values caring for older people and is skilled to do so effectively. However, given the high levels of older people in hospital most nurses will spend much of their time caring for them. Care of older people must be core skills for all nurses (with very limited exceptions) and we are not convinced that, on its own, a new category of nurse would sufficiently address overall limitations in training and education.

## Summary of key recommendations

### *A common culture made real throughout the system*

The central theme in much of the report, is a “relentless focus on the patients’ interests” and a zero tolerance approach to substandard care. Underpinning this must be a culture of openness and transparency and where there is non-compliance, serious consequences should follow.

### *Common values: putting the patient first – the NHS Constitution*

The Inquiry believes that the NHS Constitution should be the “first reference point ... [for] the system’s values, and the rights, obligations and expectations of patients”. It recommends that it should further incorporate codes of conduct and standards for staff, with which they will be expected to comply.

The Inquiry recommends a “hierarchy of standards”:

<b>Standard</b>	<b>Description</b>	<b>Overseen by</b>
1. Fundamental standards	No provider can operate without meeting these standards.	Care Quality Commission (CQC)
2. Enhanced quality standards	“Over and above fundamental standards” and enforced locally.	Commissioners (CCGs, NHSCB)
3. Developmental standards	Joint standards “setting long-term goals”.	Providers, e.g. hospitals, and commissioners (CCGs)

### *Simplifying regulation*

The Inquiry expressed concern that key regulatory organisations did not speak to each other or share information. As such, financial requirements on a Trust (Monitor) were disconnected from the quality and safety standards (CQC). They recommend incorporating Monitor into the CQC.

### *Monitoring of compliance with fundamental standards*

Fundamental standards should be policed by the CQC and developed in cooperation with front line staff, patients and the public. Indicators to measure performance should be developed by the National Institute for Health and Clinical Excellence (NICE) and would include “tools for establishing the staffing needs of each service”.

### *Enforcement of compliance with fundamental standards*

The Inquiry recommends that inspection should be the “central method for monitoring compliance”. To strengthen this, they propose establishing specialist hospital inspectors and encouraging greater collaboration with other agencies. Non-compliance with fundamental standards leading to death or serious harm to patients should be “prosecuted as a criminal offence”.

### *Applying for foundation trust status*

Monitor currently assesses application for foundation trust status – a process which grants hospitals or groups of hospitals greater independence from government. The Inquiry recommends this process should be led by CQC (once it has incorporated Monitor) and should include assessment against the fundamental standards and a physical inspection. The Trust must also demonstrate it has engaged with the local population.

### *Accountability of board level directors*

The inquiry found that there was no real means of holding board level directors to account for failures at Mid Staffs. As such, it recommends the strict application of a fit and proper person test for board level directors and the power to suspend or remove them where necessary.

### *Enhancement of governors' role*

The inquiry was concerned that governors – responsible for overseeing how a Trust is run and performs – did not appear to have the appropriate skill levels or experience. It recommends greater provision of training and establishing a minimum level of relevant experience.

### *Effective complaints and incidents*

Complaints and feedback were undervalued as a source of information and accountability. The Inquiry recommends that the complaints process should be simplified and that “any expression of concern” should be treated as a complaint. A senior clinician or nurse should have an obligation to be involved in responding to the complaint.

### *Commissioning for quality and for improvement: enhanced quality standards*

Commissioners (from April 2013: CCGs) are responsible for contracting local providers. However, they do not have a strong record in using this relationship to ensure the quality of services. The Inquiry recommends commissioners use enhanced quality standards to set out their expectations of the care they are purchasing. They will need to have access to existing instruments like ‘quality accounts’ to monitor compliance with all standards and act where there is non-compliance.

### *Local public and patient engagement and partnership*

The Inquiry considered the public involvement arrangements at Mid Staffs were “a conspicuous failure”. It recommends that Local Healthwatch – the new local public and patient champions – should “work to a [nationally] consistent structure” and that local authorities and Healthwatch England should intervene where one becomes “incapable of performing its functions”.

### *Medical training and education*

It is recommended that “students and trainees should not be placed in establishments which do not comply with the fundamental standards”.

### *There must be real involvement of patients and the public in all that is done*

The Inquiry recommends that the CQC should live up to high standards of public involvement and openness – suggesting it currently is not. It also suggests that providers should review restrictions on visiting hours.

### *Openness, transparency and candour*

The Inquiry goes into depth about the need to have a much more open approach to failure rather than the current tendency towards defensiveness. They outline a proposed duty of candour that would involve publicising and addressing failures/ issues even where there has not been a complaint. For directors, doctors and nurses, making a dishonest or “recklessly untruthful” statement to regulators should be a criminal offence. CQC would be responsible for enforcing these requirements.

### *Caring, compassionate and considerate nursing*

The Inquiry places a heavy emphasis on increasing compassion and care in nurse recruitment and training. As such, it recommends establishing national standards that reflect these values and that all trainees would be expected to fulfil. This could include an aptitude test for new recruits that would assess attitudes to care. Ward nurse managers would also be expected to work in a “supervisory capacity” and spend much more time directly involved in “patient plans and care”.

For the Nursing and Midwifery Council (NMC) – the organisation responsible for registering nurses – the Inquiry recommends a revalidation process for nurses. This would involve a person’s registration being routinely renewed based on their ongoing performance and development. They also recommend that Trusts have a “responsible officer for nursing” accountable to the NMC.

The inquiry recognises the specific skills associated with caring for older people and therefore recommends the creation of “registered older people’s nurse”.

#### *Healthcare support workers*

Healthcare support workers (HSW) carry out a great deal of the hands-on work on a ward yet are not currently registered professionals. The inquiry recommends that HSWs have a code of conduct, access to training and should be registered.

#### *Leadership*

The inquiry sets out a number of significant proposals to address the observed failures of leadership:

- Establishing a “leadership staff college” to provide “common professional training” to potential senior staff.
- “A common code of ethics, standards and conduct” for board-level staff. Serious non-compliance would result in suspension under the fit and proper person test.
- Managers should use “common minimum standards for appraisal”, which would include the need for staff to demonstrate “ongoing commitment, compassion and caring”.

#### *Proactive professional regulation of fitness to practice*

The inquiry believes that the General Medical Council – which registers doctors – and the NMC should be “proactive in monitoring fitness to practice”. They should also ensure that “patient safety is the first priority of medical training”.

#### *Caring for patients: approaches applicable to all but in particular the elderly*

The inquiry found that it is often unclear who is in overall charge for a person’s care – a particular problem for patients and families. It recommends reinstating the practice of identifying a senior clinician or nurse who is in charge of each person’s care who would also be responsible for assisting in complaints. There must also be regular ward rounds and a strong emphasis on continuity of care after a person is discharged. This would include making sure that GPs check on people once they are home and who would also assess the outcomes of the person’s care.

#### *Information*

The inquiry places a strong focus on ensuring that information collected by hospitals is open, accessible, and as close to real-time as possible. It states that “no personal or organisational interest must ever be allowed to outweigh the duty to be honest, open and truthful”. Every provider should have a designated board member as a chief information officer.