Yorkshire Ambulance Service **NHS**
NHS Trust

MEETING TITLE Public Trust Board		**MEETING DATE** 26 March 2013	
TITLE of PAPER	Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry	**PAPER REF**	5.4
STRATEGIC OBJECTIVE	Continuously improving patient care		
PURPOSE OF THE PAPER	This report provides an overview of the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry and an initial view of the implications for the Yorkshire Ambulance Service NHS Trust.		

For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☐
AUTHOR / LEAD	Steve Page Executive Director for Standards and Compliance	**ACCOUNTABLE DIRECTOR**	Steve Page Executive Director for Standards and Compliance

PREVIOUSLY CONSIDERED BY	**Committee/Group:**	**Date:**
RECOMMENDATION	It is recommended that the Board notes the key points highlighted in the Inquiry report and supports the proposed implementation and monitoring processes.	

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Register and/or Board Assurance Framework amended	☐	☒
Resource Implications (Financial, Workforce, other - specify)	☒	☐
Legal implications/Regulatory requirements	☐	☒
Quality and Diversity Implications	☐	☒

ASSURANCE/COMPLIANCE	
Care Quality Commission Registration Outcome(s)	All
NHSLA Risk Management Standards for Ambulance Trusts	All

1. PURPOSE/AIM

1.1 This report provides an overview of the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry and an initial view of the implications for the Yorkshire Ambulance Service NHS Trust.

2. BACKGROUND/CONTEXT

2.1 Robert Francis QC was initially appointed in 2009 to chair a non-statutory inquiry into the serious failings at Mid-Staffordshire NHS Foundation Trust. These failings included:

- A culture focused on system business rather than patients
- Inadequate monitoring and lack of focus on information reflecting concerns about standards of patient care
- Too great a tolerance of poor standards and risk to patients
- A failure of organisations to share knowledge about concerns
- A failure to lead the delivery of a positive culture, particularly within the nursing and medical professions.
- A failure to appreciate the disruptive nature of re-organisation and loss of corporate memory.

2.2 Many patients were found to have died unnecessarily or to have suffered significantly as a result of these failings. The key purpose of this inquiry was to give a voice to the people who had suffered and to consider what had gone wrong there.

2.3 The scope of this initial inquiry did not include consideration of the role of the wider system in the prevention or management of the situation. A further public inquiry was therefore announced on 9 June 2010, with a remit to review the contribution of the commissioning, supervisory and regulatory systems surrounding the Trust, in addition to the role of the Trust itself, and to identify lessons for the wider health care system.

2.4 The inquiry report makes 290 recommendations, covering a broad range of agencies and functions. An overarching recommendation is that all commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and decide how to apply them to their own work, producing at minimum an annual report on progress sin relation to the planned actions.

2.5 The Prime Minister and Department of Health gave initial responses to the inquiry report when it was published on 6 February 2013. The Secretary of State has since written to all Trust Chairs on the subject of ensuring an open culture, and requesting that Trusts ensure that their employee contracts and compromise agreements reflect the letter and spirit of guidance on openness.

3. FOCUS OF THE INQUIRY

3.1 The report rejects the view of many organisations at the time that there were no warning signs that things were going wrong at the hospital.

It highlights information arising from star ratings, peer reviews, Health Care Commission review, auditors' reports, staff and patient surveys, staff whistleblowing and Royal College reports. The report notes the system focus on delivering cost cutting measures without consideration of the quality impact, and that this was also the case with regard to the Foundation Trust application process.

3.2 The inquiry commented on failings of the Trust Board, local mechanisms for patient representation, General Practitioners, the PCT commissioners, the Strategic Health Authority, Monitor, the Health Care Commission and its successor the Care Quality Commission, professional regulators, deaneries and the Department of Health.

4. LESSONS LEARNED – KEY THEMES

4.1 Putting the patient first

- Ensuring that patients are the first priority
- Ensuring clarity of values and principles via the NHS Constitution

4.2 Fundamental standards of behaviour

- Values and behaviours enshrined in the NHS Constitution
- Encouraging and insisting on reporting of incidents of concern to patient safety or compliance with fundamental standards.

4.3 A common culture made real throughout the system

- Review to clearly define fundamental standards of minimum safety and quality, enhanced quality standards and developmental standards, all under one comprehensive system
- Driving of enhanced quality standards via NHSCB and CCGs.

4.4 Responsibility for, and effectiveness of, healthcare standards

- A single regulator for corporate, financial and quality governance.
- The Care Quality Commission responsible for policing the fundamental standards.
- NICE to be commissioned to formulate standard procedures and practice to support compliance.
- Direct observation key to assessment of compliance with standards
- Use of a low threshold of suspicion
- Zero tolerance of failure to meet fundamental standards
- Criminal liability where serious harm has resulted.
- Provision for the regulator to take protective steps where harm is likely
- Improved information sharing between regulatory and inspection bodies
- Additional focus on accurate and comprehensive quality accounts, and a criminal offence where accounts are wilfully or recklessly false
- Increased access to complaints information, Serious Incident reports and inquest information for the CQC
- Increased focus on CQC work with governors and scrutiny committees
- Enhanced monitoring of the Quality and Risk Profile.
- Further development of CQC capability including specialist inspectors.

4.5 Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor

- Consideration of transfer of Monitor's powers for regulating governance to the CQC.
- Authorisation process for FT under one regulator
- Development of the Trust Development Authority processes for assessment
- Implementation of a duty of utmost good faith on FT applicants.
- FT authorisation should include a full physical inspection of facilities to ensure compliance with fundamental standards,
- Enhanced role of governors
- Greater focus on accountability of provider Trust directors, including a 'fit and proper person test' and rules for removal of directors who do not meet the standards.
- Ensuring adequate ongoing training for directors

4.6 Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive

- Consideration of transfer of HSE responsibilities to the CQC
- Sharing of Serious Incidents resulting in death or serious injury of a patient with the HSE.

4.7 Enhancement of the role of supportive agencies

- Development of incentives within the NHSLA risk management standards assessments
- Introduction of standards relating to staffing levels
- Development of the role of the NPSA or successor in relation to incident monitoring

4.8 Effective complaints handling

- Development of processes to ensure learning form complaints
- Implementation of Patients Association peer review report
- Arms-length investigation of a complaint where it is a Serious Incident or under other defined criteria.
- Ensuring support for complainants in face to face meetings
- Publication of anonymised complaints on Trust websites
- OSCs and the CQC should have detailed information about complaints.
- Established processes for handling large scale complaints

4.9 Commissioning for standards

- Increased focus on the GP role.
- Focus on the role and responsibility of commissioners, need for adequate resources to enable them to monitor and enforce fundamental standards through contracts.
- Emphasis on the lead role of commissioners rather than providers in determining the service required.
- Increasing the monitoring tools and access to information for commissioners – e.g. consideration of role of commissioners in intervening in individual complaints.

- Developing public accountability mechanisms for commissioners
- Powers of intervention for commissioners where services are deemed to be unsafe

4.10 Performance management and strategic oversight

- Emphasis on clear lines of communication and information sharing between agencies.
- Focus on development of quality metrics

4.11 Patient, public and local scrutiny

- Development of Healthwatch
- Provision of expert assistance to scrutiny committees
- Powers of inspection to be given to scrutiny committees.
- Monitoring of trends in complaints by MPs.

4.12 Medical training and education

- Focus on the role of training regulators on identifying and communicating concerns about standards.
- Review of relevant GMC, Deanery and Health Education England functions
- Focus on proficiency in the English language

4.13 Openness, transparency and candour

- Focus on honesty and openness where harm has been caused by acts or omissions.
- Duty to provide accurate and complete statements to regulators and potential criminal offence if do not do so.
- Implementation of Duty of Candour
- Enforcement of Duty of Candour and criminal offence if fail to fulfil, or obstruct others, in fulfilling this duty.
- Policing of the duty buy the CQC

4.14 Nursing

- Emphasis on culture of caring
- Recruitment for values and commitment
- Strong clinical leadership
- Measuring cultural health
- Registration of and training standards for healthcare support workers

4.15 Leadership

- Shared training for NHS leaders
- Enforcement of standards and accountability
- Accreditation and potential regulatory oversight

4.16 Professional regulation of fitness to practise

- Developing the role and capability of professional regulators
- System of revalidation for nurses similar to that in place for doctors

4.17 Caring for the elderly

- Clarity of lead professional
- Focus on inter-professional communication
- Emphasis on fundamental standards

4.18 Information

- Development of shared data and electronic records
- Identification of Board members responsible for information
- Ensuring a comparable form for published quality accounts
- Regulatory oversight of quality accounts
- Public access to Quality and Risk Profiles
- Patient feedback as real time as possible
- Development of the role of the Health and Social Care Information Centre
- Development of timely, benchmarkable information on safety and quality.
- Focus on accuracy of information

4.19 Coroners and inquests

- Obligation on healthcare providers to provide all relevant information to coroners
- Rule 43 letters to be shared with the CQC

4.20 Department of Health leadership

- Publication of impact assessments of policy change before acceptance of a major proposal.
- Ensuring senior clinical input to policy decisions affecting patient wellbeing.
- Greater contact with the NHS through site visits.
- Promotion of a shared positive culture by setting an example of openness in relation to deficiencies.

5. RISK ASSESSMENT

5.1 A number of recommendations relate to the policy and practice of individual provider organisations. Whilst many of the issues have already been anticipated in recent national guidance and are being addressed through existing Trust processes, the Trust now needs to ensure a full consideration of its response to the published recommendations. Key areas of relevance include items relating to culture, leadership, accountability, openness, learning for complaints and incidents, involvement of patients and carers, monitoring and reporting of safety and quality information.

5.2 The inquiry report is currently being considered by the Department of Health. The degree to which the wider system recommendations will be accepted is therefore unknown at this stage.

5.3 If some or all of the wider recommendations are accepted, the Trust will need to give additional consideration to the impact of system changes on its internal systems and processes, and on engagement with external stakeholders.

5.4 At present no additional resource implications have been identified, although this may need to be considered further once the national response is published.

5.5 The Trust will also need to give consideration to the governance and legal implications of recommendations relating to Director liability, if these are nationally accepted.

6. NEXT STEPS

6.1 The recommendations have been reviewed by the Quality Committee and Board members also discussed the recommendations and next steps in the March Board Development Meeting.

6.2 A number of initial areas were highlighted for development and monitoring through the Quality Committee and where appropriate additional actions will be taken forward through the Trust's quality governance development plan.

6.3 It was agreed that further consideration of recommendations will be needed in the light of the Department of Health response when published, to inform the final Trust action plan.

6.4 The Department of Health has also announced a review of the NHS complaints system, focused on management of complaints, action on complaints and concerns, skills and behaviours, leadership and accountability. Further consideration of Trust complaints management arrangements will therefore be required in the light of the review findings when available.

6.5 A number of issues were highlighted with broader relevance across ambulance services. These will be highlighted in the AACE Council meeting, to facilitate national ambulance service review and opportunity for joint development in key areas.

6.6 Regular sessions have been scheduled in the Quality Committee work plan for 2013/14 for monitoring and reporting of key areas of development and relevant metrics, to provide the necessary internal and external assurance in relation to issues highlighted through the inquiry process.

6. RECOMMENDATIONS

6.1 It is recommended that the Board notes the key points highlighted in the Inquiry report and supports the proposed implementation and monitoring processes.