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Department of Health: Government response to the Mid Staffordshire Independent Inquiry Report

The Government has accepted all the recommendations of the Independent Inquiry into Mid Staffordshire NHS Foundation Trust, Health Secretary Andy Burnham announced today.

The report by Robert Francis QC, published today includes the patients' own accounts of the Trust's appalling failure to provide basic patient care between 2005 and March 2009.

Responding to the report the Health Secretary set out a package of measures to ensure the NHS nationally learns the lessons of this local failure in hospital management and patient care so they are never repeated. This includes:

· A further inquiry to be chaired by Robert Francis QC, looking at why the commissioning, regulatory and supervisory bodies did not detect the failures earlier;

· A new and robust system for senior NHS managers to ensure high professional standards and prevent failing managers from being employed elsewhere in the NHS;

· An urgent review by the General Medical Council and Nursing and Midwifery Council of the evidence in the report and consideration of whether any action is necessary;

· A dedicated working group led by NHS Medical Director, Professor Sir Bruce Keogh, to look at the complicated issue of Hospital Standardised Mortality Ratios (HSMRs) and develop a single, clearer measure for the NHS

and for patients; and

· A call for greater openness and transparency among foundation trusts with a strong presumption that, where appropriate, Trust boards should meet in public and governors should have access to papers.

The Health Secretary also confirmed that he has accepted Robert Francis's recommendation to consider asking Monitor to de-authorise Mid-Staffs and will ask Monitor to consider this when the powers come into effect in the coming months. The Health Secretary will be asking the CQC, Monitor and others for their views of the trust's long term clinical and financial prospects, and will consider initiating the process in the light of their responses.

Andy Burnham said:

"I would like to thank Robert Francis for his thorough report. It is clear that this hospital failed at every level of the organisation to ensure patients received the basic care and compassion they deserve and expect and on behalf of the Government and the NHS I would like to apologise to the patients and their families.

"All the evidence confirms this was a local failure, from which we can learn national lessons. That is why I have today announced that there will be a second independent inquiry to learn everything we can about why these failures were not detected earlier, we will introduce a robust system to monitor performance of senior managers in the NHS and will work to develop a single measure of hospital mortality rates. Together with the action we have already taken over the past year this will ensure we address every element of this case so that it won't happen again in the NHS.

"These events are unacceptable but do not reflect the experience of millions of patients that use the NHS every day or the dedication and professionalism of the majority of NHS staff. The hospital has greatly improved in the last year and I am assured by the CQC that it is safe to provide services for patients.

"The overwhelming majority of foundation trust hospitals are high performing, providing patients with the highest quality of care - but their status is a privilege, not a one-way ticket.

“A foundation trust should not retain its freedoms if it is clearly failing patients and that is why I introduced new powers to protect patients and the public - and will not hesitate to instigate de-authorisation if I believe it is necessary to do so.”

Today’s measures build on a range of actions already taken in the last year to ensure managers listen to their staff, strengthen the regulatory bodies and to make the NHS more people-centred. These include:

- Arming the Care Quality Commission with tough new powers to safeguard quality through a new system of registration;
- Plans to link up to 10% of hospital income to patient satisfaction; and
- Introducing new powers to allow Monitor to de-authorise foundation trusts where they are no longer deserving of this privileged status.

The NHS Constitution reinforces protection of staff who report wrongdoing and we require every NHS trust to have in place local policies and procedures to support staff in raising concerns under the Public Interest Disclosure Act 1998.

NHS Chief Executive Sir David Nicholson has today written to every NHS Chief and Chair in the country to urge them to reflect on the findings of this report and discuss the implications for their organisation with their boards.

Notes to editors

1. The Mid Staffordshire NHS Foundation Trust Inquiry report by Robert Francis QC was published on 24 February 2010. The report can be found at

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018

2. The report makes 18 local and national recommendations. The key recommendations for the Secretary of State are:

- Recommendation 2: the Secretary of State should consider whether he ought to request Monitor under the provisions of the Health Act 2009 to exercise its power of de-authorisation over

the Mid Staffordshire NHS Foundation Trust. In the event of his deciding that continuation of FT status is appropriate, the Secretary of State should keep that decision under review.

- Recommendation 9: in light of the findings of this report the Secretary of State and Monitor should review the arrangements for the training, appointment, support and accountability of executive and Non-Executive Directors of NHS Trusts and NHS Foundation Trusts with a view to creating and enforcing uniform professional standards for such posts by means of formulated and overseen by an independent body given powers of disciplinary sanction.
- Recommendation 15: in view of the uncertainties surrounding the use of comparative mortality statistics in assessing hospital performance and the understanding of the term 'excess' deaths, an independent working group should be set up by the Department of Health to examine and report on the methodologies in use. It should make recommendations as to how such mortality statistics should be collected, analysed and published both to promote public confidence and understanding of the process, and assist hospitals to use such statistics as a prompt to examine particular areas of patient care.
- Recommendation 16: the Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford with the objective of learning the lessons about how failing hospitals are identified.

3. The Inquiry heard evidence from patients and their families and from staff at the Trust. 966 individual members of the public and 82 current and

former members of staff directly or indirectly contacted the Inquiry. 113 witnesses gave oral evidence to the Inquiry.

4. The Health Secretary set out the Government's formal response to the Inquiry Report in an oral statement to Parliament on 24 February 2010.

5. The Department of Health has also published the following reports which support the NHS in addressing the findings of the inquiry.

- *Review of Early Warning Systems in the NHS* (authors, National

Quality Board)

- *Assuring the quality of NHS senior managers* (authors Ian Dalton, Chief Executive of North East Strategic Health Authority)
- *The Healthy NHS Board* (National Leadership Council, authors Sue Rubenstein & Adrienne Fresko)

These can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018

6. The HSMR working group led by Sir Bruce Keogh will include key parties involved in developing and using HSMRs as well as leading academics and other interested parties for example Dr Foster, the Academy of Medical Royal Colleges, the Care Quality Commission and Monitor. All key parties involved in publishing HSMR data have issued a joint statement on the value of HSMRs. This is available on the DH website at .....

7. The draft Terms of Reference of the further inquiry by Robert Francis QC can be found at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018

8. Proposals to introduce de-authorisation powers were announced in a Written Ministerial Statement to Parliament on 21 July 2009.
http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090721/wmstext/90721m0003.htm#09072146000032

9. The powers were introduced through the Health Act 2009 that received Royal Assent on 12 November 2009 and will come into force later this year.

10. For further information or a copy of the Health Secretary's oral statement to Parliament please contact the Department of Health Media Centre on 020 7210 5221.

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