RCM briefing on the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

February 2013
The Royal College of Midwives’ briefing on the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

In addition to this briefing, you might like to see the RCM’s press statement on the report, or the full report itself.

Introduction

This briefing sets out some of the key findings and recommendations in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

The Report found that the serious failings at Mid Staffordshire were primarily caused by the failure of the Trust Board to listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to its attention. It failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.

This was compounded by the failure of regulators, agencies, scrutiny groups, commissioners and professional bodies to pick up and deal with the deficiencies at Mid Staffordshire. Further exacerbating the problems was the context of extensive reorganisation and financial challenges in the NHS – many policy changes over the period were not given time to succeed before the next wave of reorganisation occurred. Accordingly, an important recommendation in the Report is that before a proposal for any major structural change to the healthcare system is accepted, an impact and risk assessment should be undertaken by the DH and should be debated publicly.

Numerous warning signs at Mid Staffordshire were not identified or acted upon, due to:

- A culture focused more on systems than patient care.
More weight attributed to positive information than to information capable of implying cause for concern.

Standards and methods of compliance that did not focus on the effect of a service on patients.

Tolerance of poor standards and risk to patients.

Poor inter-agency communication.

Failure to take responsibility for monitoring, performance management and intervention.

Inability to tackle challenges to the building of a positive culture.

A failure to appreciate the risk of disruptive loss of corporate memory and locus resulting from repeated, multi-level reorganisation.

This briefing sets out areas of particular relevance to the Royal College of Midwives, divided into the following categories: culture, professional regulation, standards and provider regulation, patient involvement and advocacy, and the Royal College of Nursing.

**Culture**

The Francis report noted that an “engrained culture of tolerance of poor standards” and disengagement of professional staff at Mid-Staffordshire was one of the major reasons for the persistence of poor care. Such cultural characteristics, while not necessarily prevalent in the NHS, are unacceptable anywhere in the system. Accordingly, the Report calls for a culture in which the patient is first in everything that the NHS does. This should be achieved by ensuring that patients receive effective care from caring, compassionate and committed staff, working within a common culture, and patients are protected from avoidable harm and any deprivation of their basic rights.

The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system’s values and the rights, obligations and expectations of patients. The report recommends that all NHS staff should commit through their employment contracts to abide by NHS values and the Constitution. Contractors in the NHS should make similar commitments.

Necessary characteristics of a common culture are openness, transparency and candour. A central theme in the Report’s evidence is that many organisations held knowledge of failings at Mid-Staffordshire, but failed to share information or act on it. Accordingly, the report recommends that a statutory obligation be placed on providers and registered professionals to observe the duty of candour; and directors
of healthcare organisations to be truthful in any information given to a regulator or commissioner. It should be a criminal offence for any registered doctor or nurse or allied health professional or director of a registered or authorised organisation to obstruct the performance of these duties or to make an untruthful statement. Further recommendations related to openness, transparency and candour are also made on regulatory inspection and patient involvement.

The Report also recommends that there should be a culture of compassion and caring throughout nurse recruitment, training and education. This includes an entry-level requirement that student nurses spend at least three months working on the direct care of patients under the supervision of a registered nurse, a revalidation scheme similar to that of the General Medical Council (GMC) (see below), and the introduction of ‘Responsible Officers for nursing’ accountable to the Nursing and Midwifery Council (NMC). Training and continuing professional development for nurses should apply at all levels. As part of a mandatory annual performance appraisal, each clinician and nurse should be required to demonstrate their ongoing commitment, compassion and caring towards patients, evidenced by feedback from patients and families, as well as from colleagues and co-workers.

A further measure to address cultural shortcomings is to improve the examples set by leaders. A leadership staff college should be created to provide common professional training in management and leadership to potential senior staff.

Professional Regulation

Evidence provided to the Inquiry demonstrated the relevance of the conduct of individual doctors and nurses. Poor performance and standards of nursing were important factors in the failings at Mid-Staffordshire. Both the GMC and the NMC have faced challenges with a lack of referrals from both professionals and the public, in part down to complex processes involved. In addition, both organisations need to be able to investigate concerns even where no named individual has been identified. The Law Commission Review of the regulation of health and social care professionals (due to report on 2014) will likely address some of these issues.

The Report recommends that the NMC should introduce a system of revalidation similar to that of the GMC as a means of reinforcing the status and competence of registered nurses. The NMC should also consider introducing an aptitude test to be taken by aspirant registered nurses prior to entering the profession to explore the candidate’s attitude to caring, compassion and other necessary professional values.

Healthcare support workers should be registered, have a uniform national code of conduct and a common set of education and training standards. The NMC should be
responsible for setting these standards and requirements of registration. In addition, the NMC should improve its ability to launch proactive investigations and its administrative functions, and raise its public profile. In addition to appointing Responsible Officers for Nursing, the NMC should also consider employment liaison officers to provide support to directors of nursing.

The Professional Standards Authority for Health and Social Care (formerly the Council for Healthcare Regulatory Excellence) should also devise procedures for the consistent handling of cases where the same event or series of events involves professionals regulated by more than one body (e.g. GMC and NMC. Consideration should also be given to developing a single independent tribunal to handle fitness to practice issues across healthcare professions.

**Standards and Provider Regulation**

*CQC and Monitor*

The report found that the plethora of regulators, agencies, scrutiny groups, commissioners and professional bodies failed to respond in an effective way to the identified problems. There was poor communication between these bodies, lack of clarity about responsibilities, followed by failure to monitor the adequacy of any actions taken.

Monitor’s approach focused on the Foundation Trust’s (FT’s) finances. It appeared that the quality of care was not its direct concern. The erroneous authorisation of the Trust as an FT came about almost entirely because the Health Care Commission and Monitor were separate organisations, going about their regulatory business without coordinating their activities. No effective consideration was given to the potential effects of cost savings and staff cuts on patient safety and quality.

The report recognises the many challenges faced by the Care Quality Commission since its inception but is critical of its continued lack of recognition of the importance of patient and family feedback. A contact with complainants should be a significant element of inspection. The report also recommends that CQC have access to safety information obtained by the National Patient Safety Agency or its successor to identify areas for focusing its attention.

The report recommends that there should be single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts. This merger of regulatory functions between Monitor and the Care Quality Commission needs to be undertaken
incrementally and should not be used as a justification for reduction of the resources allocated to this area of regulatory activity.

Standards

The NHS Constitution should set out a commitment to abide by an integrated hierarchy of standards: fundamental standards, which need to be applied by all who work and serve in the healthcare system; enhanced quality standards, over and above fundamental standards; developmental standards, setting longer term goals.

Compliance with the fundamental standards should be policed by the regulators. These indicators should be produced by NICE, including evidence-based tools for establishing the staffing needs of each service.

Non-compliance with a fundamental standard leading to death or serious harm should be capable of being prosecuted as a criminal offence.

Inspection should remain the central method of monitoring compliance with fundamental standards.

Applying for FT status

In the context of the inappropriate FT status awarded to Stafford, the report recommends that applications should be only be supported when there is documented compliance with the fundamental standards. The NHS Trust Development Authority should develop a rigorous process for assessment that must include as a priority focus a review of the standard of service delivered to patients, and the sustainability of a service at the required standard. Local stakeholder and public opinion should also be sought on the fitness of a potential applicant.

Commissioning

The report is critical of the time taken by the local PCT to address issues identified in the HCC investigation. Responsibility for driving improvement in the quality of services rests with the commissioners through their commissioning arrangements. Commissioners should promote improvement by requiring compliance with enhanced standards that demand more of the provider than the fundamental standards. The commissioner should be able to stop the provision of a service when it is found to be in breach of the fundamental and/or enhanced standards.

The public should be able to compare relative performance and therefore needs access to open, honest and transparent information to assess compliance with appropriate standards.
Patient involvement and advocacy

The failure of the Trust Board in Stafford to listen to its patients is demonstrated in its dysfunctional Patient and Public Involvement Forums, the inadequacy of the complaints procedure and the lack of support throughout the process.

The Board appeared to have a sceptical response to the validity of complaints and did not investigate them in detail. Such a disinterested approach clearly ignored the value of complaints in informing them of what was going wrong, and what, if anything was being done to put it right.

There was also evidence that the Patient Advice and Liaison Service did not share information about complaints with the local Overview and Scrutiny Committee (OSC) which, in turn, had not asked for it. Thus, DH guidance suggesting that information about complaints would be of “crucial input to the scrutiny process” was ignored.

The content of complaints and responses to them should be used by commissioners and the regulatory bodies. Learning from complaints needs to be effectively identified, disseminated and implemented. Actions in response to the complaint must be made known to the complainant and the public. The report suggests there is a case for independent investigation of a wide range of complaints.

Not surprisingly, in this culture, the Trust’s Patient and Public Involvement Forums (PPIFs) and later engagement with local Involvement Networks (LINks) failed to achieve anything but mutual acrimony between members. The public in Stafford were therefore left with no effective voice.

The Royal College of Nursing

The Inquiry heard from a number of witnesses, including Sir Stephen Moss (Chair of Mid Staffordshire NHS Foundation Trust between August 2009 and January 2012), that the effectiveness of the RCN was hindered by the perceived conflict of interest across its dual professional and trade union functions. A given example was the role of the RCN in representing the nursing sisters who were the subject of Helene Donnelly’s whistleblowing complaint, and the promotion of standards of nursing that might be expected of a professional Royal College. It would be very difficult for the same organisation to do both at the same time. The Inquiry concluded that the RCN was not heard as well as it should have been in pursuing professional concerns about the standard of care at Mid Staffordshire. Accordingly, the Report recommends that the RCN should consider dividing its professional association and trade union functions between two bodies, rather than across internal divisions.