Press Release

6 February 2013

Publication of the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Today, Robert Francis QC, Chairman of the Inquiry publishes his final report following consideration of over 250 witnesses and over one million pages of documentary evidence.

The Inquiry has been examining the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It has been considering why the serious problems at the Trust were not identified and acted on sooner, and identifying important lessons to be learnt for the future of patient care. It builds on Mr Francis's earlier report, published in 2010 after the earlier independent inquiry on the failings in the Mid Staffordshire NHS Foundation Trust between 2005 and 2009.

The Inquiry identifies a story of terrible and unnecessary suffering of hundreds of people who were failed by a system which ignored the warning signs of poor care and put corporate self interest and cost control ahead of patients and their safety.

Today the Chairman makes 290 recommendations designed to change this culture and make sure patients come first by creating a common patient centred culture across the NHS.

The Chairman's recommendations include:

- **A structure of fundamental standards and measures of compliance:**
    - A list of clear fundamental standards, which any patient is entitled to expect which identify the basic standards of care which should be in place to permit any hospital service to continue.
    - These standards should be defined in genuine partnership with patients, the public and healthcare professionals and enshrined as duties, which healthcare providers must comply with.
    - Non compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service which exposes a patient to risk
    - To cause death or serious harm to a patient by non compliance without reasonable excuse of the fundamental standards, should be a criminal offence.

- Standard procedures and guidance to enable organisation and individuals to comply with these fundamental standards should be produced by the National Institute for Clinical Excellence with the help of professional and patient organisations.
- These fundamental standards should be policed by the Care Quality Commission (CQC)

- **Openness, transparency and candour throughout the system underpinned by statute. Without this a common culture of being open and honest with patients and regulators will not spread. Including**:
  - A statutory duty to be truthful to patients where harm has or may have been caused
  - Staff to be obliged by statute to make their employers aware of incidents in which harm has been or may have been caused to a patient
  - Trusts have to be open and honest in their quality accounts describing their faults as well as their successes
  - The deliberate obstruction of the performance of these duties and the deliberate deception of patients and the public should be a criminal offence
  - It should be a criminal offence for the directors of Trusts to give deliberately misleading information to the public and the regulators
  - The CQC should be responsible for policing these obligations

- **Improved support for compassionate, caring and committed nursing**
  - Entrants to the nursing profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of patients
  - Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard
  - Nurses need a stronger voice, including representation in organisational leadership and the encouragement of nursing leadership at ward level
  - Healthcare workers should be regulated by a registration scheme, preventing those who should not be entrusted with the care of patients from being employed to do so.

- **Stronger healthcare leadership**
  - The establishment of an NHS leadership college, offering all potential and current leaders the chance to share in a common form of training to exemplify and implement a common culture, code of ethics and conduct
  - It should be possible to disqualify those guilty of serious breaches of the code of conduct or otherwise found unfit from eligibility for leadership posts

- A registration scheme and a requirement need to be established that only fit and proper persons are eligible to be directors of NHS organisations.

Mr Robert Francis QC said:

"We need to ensure fundamental standards are enforceable by law – and the criminal law in the most serious of cases. Senior managers should be made accountable, patients need to be protected from poor nursing standards and all staff should be empowered to be open and transparent when it comes to the well- being of the people in the care.

The NHS can provide great care and the system and the people in it should make sure that happens everywhere. The recommendations I am making today represent not the end but the beginning of a journey towards a healthier culture in the NHS where patients are the first and foremost consideration of the system and all those who work in it. It is the individual duty of every organisation and individual within the service to read this report and begin working on its recommendations today."

Ends

Notes to Editors

Robert Francis QC chairs the Public Inquiry, which has been set-up under the Inquiries Act 2005 and Inquiry Rules 2006. It examined the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It considered why the serious problems at the Trust were not identified and acted on sooner, and identifying important lessons to be learnt for the future of patient care.

The then Secretary of State for Health, Andrew Lansley, announced the establishment of the Public Inquiry to Parliament on 9 June 2010

Background on the Inquiry

- The Procedural Hearing was held on **20 July 2010**

- Oral hearings – began on **8 November 2010** in Stafford and concluded on **1 December 2011**

- The Inquiry itself sat for a total of **139** days

- In total, the Inquiry heard from **164** witnesses in person. In addition, **87** witness statements and **39** provisional statements were 'read' into the Inquiry's record. The Inquiry took **352** separate witness statements in total.

- Over a million pages of material was disclosed to the Inquiry (the Inquiry Database contains **64,319** documents and **1,190,648** pages)

- During the course of the Inquiry hearings **55,265** pages were used by Trial Director

- Costs of the Inquiry up to November 2013 are approximately **£13 million**

Since 9 June 2010, the Inquiry has been through several stages:

- **July to August 2010 –** four assessors were appointed and the Inquiry began requesting evidence
- **8 November 2010 to 1 December 2011**– public hearings were held to explore the evidence of important witnesses and examine key documents
- **October to November 2011** – a series of seven public seminars were held to explore the 'forward-looking' part of the Inquiry's terms of reference
- **December 2011 to February 2012** – a series of seven fact-finding visits were undertaken to a variety of healthcare organisations
- **December 2012** - the appointment of four independent health expert assessors were announced to assist the Chairman in reviewing his final recommendations.
- **23 January 2013** – the Chairman announced that, following agreement from the Secretary of Health, he would hand over the final report on 5 February 2013 and publish it on 6 February 2013.

For further information, please contact the Inquiry Press Office on 020 79726024 or pressoffice@midstaffsinquiry.co.uk or visit the website at: www.midstaffspublicinquiry.com