Item: Mid Staffordshire Inquiry Report

Synopsis:

This paper provides the Trust Board with an overview of the national guidance published to assist them using the learning from the Mid Staffordshire Inquiry to review their governance and management of quality.

The Trust Board is requested to review the proposed actions and approve.

Author: Head of Integrated Governance and Quality

Presented by: Mary Sexton, Director of Nursing, Quality and Governance

Action Required:

Discussion and Approval
Mid Staffordshire Inquiry Report

Date: March 2010
Author: Sharon Gardner-Blatch, Head of Integrated Governance and Quality
Department: Integrated Governance and Quality
Audience: Trust Board Members

Introduction

Robert Francis QC was commissioned by the Secretary of State Andy Burnham to undertake an inquiry into the failings identified by the Healthcare Commission into the Mid Staffordshire NHS Foundation Trust which has been published in March 2010.

The Inquiry report identified key areas where there were systemic failures to maintain the correct standards of practice and to provide a quality service. The report contains 18 recommendations which have been made to the Trust, Department of Health and Monitor. These recommendations have been accepted in full.

The Department of Health has recommended three reports, as discussed in this paper, to assist all NHS organisations in learning from and responding to the recommendations of the report. The reports align a strategic approach which will assist in embedding effective governance and detecting, preventing serious failures from recurring.

This paper provides the Trust Board with an overview of the three reports and makes organisation specific recommendations for discussion and consideration to assist the organisation maximise its learning and development for the benefit of its stakeholders.

The Department of Health Response

The Chief Executive of the NHS has required, as a matter of urgency, that every NHS Board read the Mid Staffordshire Inquiry report and review their standards, governance and performance in light of the report. Sir David Nicholson states ‘My expectation is that every NHS Board reads the report in full, but also actively considers the implications for the way that they do their business; how the Board assures itself and the community it serves of the quality and safety of the services you provide and commission’. ‘It is the role of NHS Boards to remain eternally vigilant and relentless in the pursuit of better quality care. Our approach to increasing productivity must be driven by a desire to improve quality. We know that poor care is often inefficient care and that we will release the necessary efficiencies by focussing our attention on quality, innovation and prevention.

The Department of Health acknowledge that much of the failings were within the Mid Staffordshire Trust itself. However, it recognises the recommendations that will be pursued nationally as
1. Reviewing the arrangements for the training, appointment, support and accountability of Executive and Non Executive Directors of NHS Trusts and Foundation Trusts – the Government will be consulting on having a professional accreditation system for senior managers. It should be noted that certain Board Members are already subject to professional regulation by their professional body.

2. The Department of Health will set up a working group to examine report and advise on the methodologies in use to provide comparative mortality statistics.

3. Provide Boards with guidance on how to bridge the gap from Board to ward to improve their effectiveness through building on the National Leadership Council work published in The Healthy NHS Board.

4. There is to be a further inquiry into the role of external agencies and what lessons might be drawn for the new regulatory system to ensure that failing hospitals are identified as is practicable. This work will build on the report of the National Quality Board into early warning systems.

Sir David Nicholson concludes by stating that ‘It is the duty of all Board Members to use the information not to police the boundaries of their own organisation but to protect the interests of the patients and public the Board serves’.

The approaches suggested in the three published reports

‘Reviews of Early Warning Systems in the NHS’ - National Quality Board

The Healthy NHS Board: principles for Good Governance – National Leadership Council

‘Assuring the Quality of Senior NHS Managers’ Department of Health

Are outlined in this paper for consideration by the Board alongside the governance work it has been undertaking since the Mid Staffordshire NHS Trust Inspection report published by the Healthcare Commission in March 2009.

Reviews of Early Warning Systems in the NHS

This report provides a review of the systems and processes currently in place within the NHS for safeguarding quality and preventing serious failures. This review has been undertaken by the National Quality Board who undertake a work programme based on

Aligning the NHS system around quality
Advising on priorities for quality improvement
Overseeing the development of tools and system levers to support frontline NHS in bringing about continuous quality improvement

In this report they describe how the system should work in the future in order to prevent – and where necessary, respond to serious failures in quality. This has been achieved in the main through providing clarity around the roles and responsibilities of individuals and organisations for safeguarding quality in the face of a changing regulatory regime.
The report recognises that whilst the systems and processes are important, the extent to which success or failure rests on the values and behaviours of staff in putting patients and service users first and the culture both within and between organisations.

**Assuring the Quality of NHS Managers**

In Lord Darzi’s report ‘High Quality Care for All’ a series of measures for improving quality was set out. These included improving education and training and enabling NHS staff to lead. The National Leadership Council has been set up with the aim of delivering a step change in the development of leadership across healthcare to continue this work. The Department of Health commissioned a research study to support policy development in relation to quality assuring NHS Senior managers i.e. Chief Executive and Board level staff.

The research study has identified that there are no accreditation or regulatory systems in place for generic managers that could be easily transposed or adapted into an NHS setting. There is a general recognition that the vast majority of senior NHS managers are performing to a high standard and operating within a complex and challenging environment. Further whilst it is recognised that the direct contact with patients is different to that of Drs and nurses their actions do have a direct impact on large numbers of patients through their decisions.

During the stakeholder engagement phase of the research study interviews elicited recurrent themes on the key success factors for fair and effective arrangements for quality assuring senior managers. The recurrent themes were; leadership, Board support and ongoing development opportunities.

The research study and stakeholder engagement identified that an approach based on a framework of options for implementation will assist in successful recruitment, support in their role and future development. The framework of options included

- **Strand 1 Recruitment, vetting and employment**
- **Strand 2 Corporate Governance**
- **Strand 3 Accreditation, Licensing and Regulation**

This paper does not conclude the approach that will be adopted but makes recommendations that the aims of the system be clear with the primary aim being to improve quality in senior leadership and management whilst at the same time developing a framework to address poorly performing managers.

The timeframe for actions arising from this research study is as yet not known. However, local adoption can be progressed locally through the recommendations in ‘The Healthy Board’ and utilising the systems and processes currently in place e.g. Appraisals and Development reviews.

**The Healthy NHS Board – Principles for Good Governance**

Published by the National Leadership Council this report ‘brings together the latest research, evidence and thinking’ to assist Boards in addressing the challenges of improving the quality for patients. It sets out guiding principles that allow NHS Board members to understand the
Collective Role of the Board

The governance role within the wider health system

The activities and approaches that are most likely to improve board effectiveness

Contributions expected from them as individual board members.

The approach of the document is to identify the enduring principles of high quality governance, which transcend immediate policy imperatives and the more pressing features of the current healthcare environment.

It recognises the role of NHS Trust Boards is to ‘govern effectively and in doing so to build public confidence that their health and healthcare is in safe hands. This is delivered by building confidence;

In the quality and safety of health services

The way in which resources are invested to deliver optimal health outcomes

The accessibility and responsiveness of health services

That the public can appropriately shape health services to meet their needs

That public money is spent in a way that is efficient and effective

This paper does not prescribe a model of governance but acknowledges the range of models in use in the public and private sectors e.g. agency model, stakeholder model, stewardship model, policy governance and generative governance. It does however explore the key roles of the Board and provide a focus for any development toward improved board effectiveness.

Conclusion

The Mid Staffordshire Inquiry report is at best a sobering window on how Board decisions in relation to their focus, culture and poor use of intelligence can impact on large numbers of people who have come to the organisation for care and treatment. There is no Board in the country that would want to preside over an organisation delivering a systematic lack of basic standards of care and treatment.

Surrey and Sussex Healthcare NHS Trust Board has been reviewing its governance arrangements and their effectiveness since the Healthcare Commission report in March 2009. There has been a focus on risk management and patient safety which will continue. In addition to this the Trust Board is reviewing its sub committees functions and governance to prescribe further clear accountabilities, aligned reporting structures, intelligent information and development at all levels in the organisation.

Action
The Board is requested to approve that the governance function is authorised to review the recommendations contained in these reports and produce a proposal to optimise the potential development and learning to mitigate risks at SASH.

It is suggested this will include

Board development – clarity on the model of governance to be used, accountability arrangements, systems of control and assurances, use of information, organisational culture development, embedding board disciplines, delegating appropriately, defining organisational outcomes for stakeholders, and clearly defined Board member roles.

Accountability – holding the organisation to account for delivering the strategy, seeking assurance on the system of control, the use of intelligence and performance information, stakeholder mapping, competitor analysis, health need and demography and engagement, aligned systems.