Gateway reference : **To:** All NHS Chairs **CC:** All NHS Chief Executives All Medical Directors All Nurse Directors All Director of HR/ personnel All NHS Foundation Trusts Monitor Care Quality Commission Gateway reference: 13684	**Richmond House** *79 Whitehall* *London* *SW1A 2NS* *020 7210 5142* david.nicholson@dh.gsi.gov.uk

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Dear Colleague,

Robert Francis QC Mid-Staffs Inquiry Report

The Next Stage Review (NSR) process involved thousands of patients, public and staff and helped to develop a powerful consensus that quality must lie at the heart of all that the NHS does. If anyone was ever in any doubt that this was the right vision or strategy for the NHS, then the report published this week by Robert Francis into Mid-Staffordshire provides salutary reading.

I am writing personally to every NHS board today to ask you, as a matter of urgency, to read the report of the Mid-Staffordshire Inquiry and to review your standards, governance and performance in the light of this. I am sure you will read the press coverage, but this is no substitute for reading the report and the patient stories in full. I am sure that you, like me, will be deeply moved at what you read, because the standard of care described in the report falls so short of what we all aspire to provide in the NHS.

Both the Government and the Trust have accepted all of the recommendations from Robert Francis. Whilst there is clearly still much to do, the new leadership team at the Trust is making real progress and it is important that we now allow the Trust the space to make the improvements it needs to make. It is right that our attention now shifts to what lessons might be learned elsewhere within the system. My expectation is that every NHS board reads the report in full, but also actively considers the implications for the way that you do your business; how you as a board assure yourselves and the community that you serve of the quality and safety of the services you provide and commission.

I know that many of you will have already begun these conversations, as Trusts are now required to apply to register with the new Care Quality Commission and make a declaration as part of this process. For the first time this Summer every NHS hospital will also be required to publish Quality Accounts. Just as they are currently required to publish financial accounts, Trusts will now have to publish a public facing account of the quality of care provided. This will eventually be a requirement for all NHS organisations.

These developments, combined with the many other ways that we are putting quality at the heart of all we do, such as linking payment to patient experience, will all help drive further service improvement. But I would still urge you to read the report of the Mid-Staffordshire Inquiry and consider what further steps as a board you may wish to take.

I do not think that Mid-Staffordshire then is in any way typical of the care that you and your staff provide to patients day and day out. Every 36 hours the NHS treats 1 million people, many of whom have their lives saved or improved because of the care they receive from dedicated NHS staff. But we should not be complacent. Indeed, it is the role of NHS Boards to remain eternally vigilant and relentless in the pursuit of better quality care. This is particularly important as we enter a period of tougher economic circumstances and it is why I have stressed that our approach to increasing productivity must be driven by the desire to improve quality. We know that poor quality care is often inefficient care and that we will release the necessary efficiencies by focussing our attention on quality, innovation and prevention.

There is always more that we could and should do. And this is true at every level of the system. Whilst the Francis report makes clear that the prime responsibility for the failings at the Trust lie within the Trust itself, he does make a number of recommendations that we will be taking forward nationally, including:

Reviewing the arrangements for the training, appointment, support and accountability of executive and Non-executive Directors of NHS Trusts and Foundation Trusts

The Government has accepted the recommendations of a report from the National Leadership Council that proposes a new system of professional accreditation for senior managers. We will now consult with the profession and the public on the best way of taking this forward, including whether it should be extended to Non-Executives. In addition, the National Leadership Council has also published *The Healthy NHS Board*. This updated guidance will help boards improve their effectiveness and bridge the gap between the board and the ward.

In view of the uncertainties surrounding the use of comparative mortality statistics and independent working group should be set up by the DoH to examine, report and advise on the methodologies in use

The NHS Medical Director, Professor Sir Bruce Keogh, has already established a working group involving key parties and leading academics and they have committed to develop a single hospital standardised mortality ratio (HSMR) for the NHS. He has also asked the NHS Confederation to develop a practical guide to the use and interpretation of HSMRs for the NHS. All key parties issued a joint interim statement (attached at annex A) today making clear that HMSRS can be a useful indicator but they have limitations and should not be used as a sole indicator of patient safety.

The Secretary of State should consider whether he ought to request Monitor to exercise its power of de-authorisation over the Mid-Staffordshire Foundation Trust

Secretary of State has accepted Robert Francis's recommendation to consider asking Monitor to de-authorise Mid-Staffordshire NHS Foundation Trust.

His strong view, in the light of the Inquiry report and the support that the Trust is likely to need in the medium and long term, is that he will ask Monitor to consider de-authorising when the powers come into effect in the coming months. He will therefore ask the CQC, Monitor and others to give him their views of the Trust's long-term clinical and financial prospects, and will consider initiating the process in the light of their responses.

Whilst the report into Mid-Staffordshire makes clear that the prime responsibility for the failings lay with the Trust itself, there are clearly lessons for the wider NHS and regulators. Robert Francis has therefore agreed to Chair a further inquiry to consider the role of external agencies and what lessons might be drawn for the new regulatory system, to ensure that failing hospitals are identified as soon as is practicable. This next stage of his review will build on the report of the National Quality Board (NQB) into early warning systems, also published today. The purpose of the NQB report is to set out very clearly what the respective roles and responsibilities of each and every NHS organisation is in preventing failure. I would urge every board to familiarise themselves with this so that we have absolute clarity.

Scrutiny can be uncomfortable, but it undoubtedly leads to better outcomes. We learnt together through the NSR process that quality can only be improved if you have a clear definition that includes patient experience; if clinicians measure and understand the quality of care that they provide and if the system ensures that this is published, rewarded and challenged where appropriate.

As a member of an NHS Board it is your duty to use this information not to police the boundaries of your own organisation but to protect the interests of the patients and public you serve. The report published yesterday by the National Leadership Council, *The Healthy NHS Board,* will help you to do that.

What happened at Mid-Staffordshire is a stark illustration of why we need to deliver our vision of an NHS where quality is at the heart of all that we do. It also highlights the central importance of listening to and acting on the voices of our patients, public and staff. It is not possible to undo the harm that was done to patients and their families in Mid-Staffordshire, but we must take the lessons forward and ensure that the wider NHS improves as a result.

Sir David Nicholson KCB CBE
NHS Chief Executive