



Royal College
of Nursing

Mid Staffordshire NHS Foundation Trust Public Inquiry Report

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Context



- Events at **Stafford hospital**: Up to 1,200 unnecessary deaths between January 2005 and March 2009
- In June 2010 (following previous inquiries) Prime Minister announced a full public inquiry into events at the hospital
- Inquiry chaired by Robert Francis QC
- Terms of reference: *“to examine why problems at the Trust were not identified sooner, and appropriate action taken”*
- Francis report published on 6th February 2013
- All organisations in healthcare have to consider the recommendations of the report
- Government responded on 26th March 2013
- RCN responded on 15th July 2013

Report by Robert Francis QC care failings at Stafford hospital

290 recommendations covering causes and early warning signs including:

- Staffing levels
- Strengthening Leadership
- Regulation of health care support workers
- Improving culture and complaint handling processes
- Strengthening regulation (both professional and system)
- Strengthening nursing
- Putting patients first and standards of service



Robert Francis Press Conference Statement

6/2/13



- “The **Trust Board was weak**. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust’s attention. It did not tackle the tolerance of poor standards and the disengagement of senior clinical staff from managerial and leadership responsibilities. These failures were in part due to a **focus on reaching targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable standards of care**”

Leadership

- Strong Nursing voice at board level
- Ward nurse managers should operate in a supervisory capacity, and not be office-bound
- That each patient has at all times a named key nurse.
- Training and continuing professional development for nurses should include leadership training at every level from student to director

Staffing levels

- Recommended stronger guidance for setting safe staffing levels
- Board Directors must consult their clinical and nursing directors when staffing levels are changed and record their responses.

“Evidence to this Inquiry suggested that the Trust did not have available to it reliable figures for its nursing establishment, either in theory or in practice... **What is clear is that the numbers had always been tight and declined during the period with which the Inquiry is concerned**”

RCN's response

- Safe staffing “Failure to tackle unsafe staffing would be to fail patients entirely”
- Support for the role of the “named nurse” as a mechanism to organise work around the needs of the patient rather than a series of tasks
- Focus on the importance of strong nurse leadership and backing of increased educational opportunities for senior staff, with supervisory ward sisters free to lead and mentor nurses
- More must be done to improve the culture in the NHS and tackle the “care fatigue” experienced by some longer-serving health care staff
- Push for mandatory training and regulation of health care assistants

