INQUIRY INTO THE OPERATION OF THE COMMISSIONING, SUPERVISORY AND REGULATORY BODIES IN RELATION TO THEIR MONITORING ROLE AT MID STAFFORDSHIRE NHS FOUNDATION TRUST

Terms of Reference

Robert Francis QC recommended that the Department should consider an independent examination of the role of the commissioning**,** supervisory and regulatory bodies in the monitoring of Mid-Staffordshire NHS Foundation Trust.

Following that recommendation, he has been invited to build on the work of the Inquiry into the care provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009, by undertaking an investigation into the role of the commissioning**,** supervisory and regulatory bodies and systems in detecting and correcting deficiencies in service provision of the type he has identified.

The systems in place are now different from those in place at the time of the events he has reviewed. The Inquiry will take into account these developments as identified by, among others, the National Quality Board's *Review of Early Warning systems in the NHS*, in looking for the lessons to be learned.

The Inquiry will be conducted under the Inquiries Act 2005.

Comments were sought from interested parties on the draft Terms of Reference and we have considered these views in setting the Terms of Reference for this further independent inquiry.

The Terms of Reference for this further inquiry are:

- to examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner; and appropriate action taken**.** This includes, but is not limited to, examining, the actions of the Department of Health, the local Strategic Health Authority, the local Primary Care Trust(s), the Independent Regulator of NHS Foundation Trusts (Monitor), the

Care Quality Commission, the Health and Safety Executive, local scrutiny and public engagement bodies and the local Coroner. [1]

- where appropriate to build on the evidence given to the first inquiry and its conclusions, without duplicating the investigation already carried out, and to conduct the inquiry in a manner which minimises interference with the Mid-Staffordshire NHS Foundation Trust's work in improving its service to patients.

- to identify the lessons to be drawn from that examination as to how in the future the NHS and the bodies which regulate it can ensure that failing and potentially failing hospitals or their services are identified as soon as is practicable.;

- in identifying the relevant lessons to have regard to the fact that the commissioning**,** supervisory and regulatory systems differ significantly from those in place previously and the need to consider the situation both then and now; and

- to make recommendations to the Secretary of State for Health based on the lessons learned from the events at Mid Staffordshire; and to use best endeavours to issue a Report to him by March 2011.

The Chair will decide the precise scope of the Inquiry and details of how, and where, the Inquiry will be conducted.

The Chair will be able to appoint an expert panel with expertise in regulatory systems and NHS management to support the Inquiry's work, including non-NHS experts, with expertise in regulatory, business and management structures.

[1] This list should also include predecessor bodies of these organisations where relevant in accordance with the time period the Inquiry is examining