Understanding the Francis Report

The long-awaited Francis Report, published in February 2013, makes for compelling reading. It comes at a time when many of us healthcare professionals have to deal with ever-increasing pressures to cut costs while at the same time striving to maintain quality in the care we provide our patients. It is important for all of us to examine this report carefully and assimilate the key messages from it.

Background

Robert Francis QC was first commissioned in July 2009 to chair a non-statutory inquiry in the then Mid Staffordshire General Hospital NHS Trust. This was triggered by the high mortality rates of the trust in 2007. The results of the first enquiry published in February 2010 concluded that there was a lack of basic care to patients across several wards and departments. The Board was accused of being more interested in achieving FT (Foundation Trust) status and concentrated more on statistics and reports than the outcomes of patient experience. More importantly it was damning on the role played by external organisations such as the PCT (Primary Care Trust) which had not identified the concerns till the investigation by the HCC (Health Care Commission) in 2009. The enquiry recommended that Monitor de authorise the Mid Staffordshire NHS Foundation Trust when the power came into effect, and suggested that there should be a public enquiry to investigate the issues highlighted in the first enquiry. The Department of Health and the Trust Board accepted all the recommendations of the first enquiry and the second enquiry, before a public enquiry was commissioned by the Government under the leadership of Robert Francis QC in June 2010. This report was finally published in February 2013 and consisted of over 1000 pages of detailed analysis and recommendations. The shorter 125 pages of executive summary provide a good feel of the complete report.

The Report

The report commences with a consideration of key warning signs of poor care that existed in Mid Staffs, that should have triggered corrective action but did not. The next section explores issues relating to the governance and culture of the Trust. This is followed by an examination of the role of patient and public involvement groups, the commissioners, the SHA (Strategic Health Authority), and the regulators to understand what went wrong and to consider the role of other organisations. The conclusion of the report deals with themes relevant to the present and future, with recommendations.

Warning Signs

Robert Francis QC unearths a whole series of events which in itself should have triggered an enquiry as early as 2004 with the reduction in its star rating, when the Commission for Health Improvement (CHI) re-rated the Trust, and it went from a three-star trust to zero stars. The HCC commissioned annual surveys of staff and patient opinion which revealed that the trust was in the worst performing 20 % in the country. A whistle-blowing incident involving a staff nurse's report in 2007 was also ignored. Against a background of problems the trust announced staff cuts, which was not questioned by the SHA. The HCC meanwhile was preparing to investigate claims of poor care, but did not know that at a national level the trust was being considered for FT status. Finally, Monitor did not know about HCC's impending investigation until after it had given the FT status to the hospital in 2009. A breathtaking series of incidents over a period of five years should have alerted someone, somewhere to the magnitude of the problem unfolding within the hospital walls, but unfortunately did not.

Analysis of Evidence

The inquiry report examines the role played by each organisation on what they should have known and done in response to concerns raised. It is critical of the trust board not responding to the concerns that were raised to it, the SHA for raising these concerns to the Department of Health (DoH) at the time of the FT application, and Monitor for awarding the FT status without properly assessing the trust's capability of delivering effective patient care. The lack of communication between various organisations was highlighted as the key problem. Further, the report highlights the disconnect between policy decisions being made and their practical implementation. It has been rightly pointed out that the setting of national standards in itself will not "catch" a Mid Staffordshire, but it is more importantly the establishment of robust and effective methods to police those standards, which will eventually prevent another Mid Staffs occurring.

Key Recommendations

The report makes 290 recommendations, and the following are some key ones.

A common culture made real throughout the system - Openness, transparency and candour

The report highlights the need for changing the current culture of fear to a culture "where the only fear is the failure to uphold the fundamental standards and the caring culture". The recommendation is that it should be a criminal offence for any registered doctor or nurse or allied health professional or director of a registered or authorised organisation to obstruct the performance of these duties or dishonestly or recklessly make an untruthful statement to a regulator.

Monitoring of compliance with fundamental standards
The importance of having clear and simple standards that both providers and patients can understand has been highlighted. These standards should be informed by an evidence base and be effectively measurable. The fundamental standards should be policed by a single regulator, the CQC, monitoring compliance as well as governance and financial sustainability. There is a recommendation that NICE should produce evidence-based tools for establishing the staffing needs of each service.

Enforcement of compliance with fundamental standards
There is an expectation of zero tolerance, with a service incapable of meeting fundamental standards not being permitted to continue. Further, non-compliance with a fundamental standard leading to death or serious harm of a patient should result in prosecution as a criminal offence, unless the provider or individual concerned can show that it was not reasonably practical to avoid this.

Effective complaints handling
A new recommendation has been introduced for an independent investigation of a complaint to be initiated by the provider trust under certain circumstances, such as if a complaint amounts to an allegation of a serious untoward incident or a complaint raises substantive issues of professional misconduct or the performance of senior managers.

Applying for foundation trust status
There is an ongoing recommendation for the merger of CQC and Monitor, and numerous suggestions for tightening up the process including physical inspection of sites by CQC prior to awarding FT status.

Accountability of board-level directors
The report tackles the issue of lack of accountability currently among board-level directors. A finding that a person is not fit and proper to undertake the role of director may henceforth disqualify them from being a director of any other healthcare organisation, and they could themselves be also reported to the regulator.

Medical training and education
The report recommends that students and trainees should not be placed in organisations which do not comply with the fundamental standards. Further, those charged with overseeing and regulating these activities should now also make the protection of patients their priority. The General Medical Council's system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training.

Caring, compassionate and considerate nursing
The report has asked for an increased focus on a culture of compassion and caring in nurse recruitment, training and education. The report would like to see ward nurse managers work in a supervisory capacity and not be

office-bound. The Nursing and Midwifery Council should introduce a system of revalidation similar to that of the GMC with a responsible officer for nursing in each trust. To tackle the issues of poor care noted among elderly patients, one suggestion is to create a new status of a registered older person's nurse.

Quality accounts with information about an organisation's compliance or non-compliance with the fundamental standards should be made available on each trust's website.

Robert Francis has recommended that every organisation should announce, at the earliest, its plans on how it is going to accept and implement the recommendations, and within the year publish a report with its progress towards these recommendations.

It is important that we participate in these changes in our organisation and make the improvements happen.

Conclusion

The Bristol enquiry was a wake-up call to the medical profession and it was believed, at the time, that lessons would be learnt. However this does not appear to be the case and the Francis Report proves this. The word "hindsight" occurred at least 123 times in the transcript of the oral hearing and "benefit of hindsight" 378 times. Empowered with the "hindsight" provided by the lessons from the Bristol enquiry and many others that followed, the Mid Staffs disaster should not have happened. Yet we let it happen.

The Francis Report is yet another wake-up call to professionals like us. As Robert Francis QC pointed out, the system cannot make the change for the better, it is the individuals in the system that can. Is there a hospital near you, or perhaps even yours, which may be declared as the next "Mid Staffs"? We need to be courageous to speak up and stand up for the patients that we serve. The big question is ... will we?

Robert Francis asks for a culture change in a climate fraught with tensions between management and clinicians. Consultant morale is the lowest it has been in years, and not enough nurses can even be recruited into the posts. Further nursing profession regulations could potentially make the nursing profession unattractive for new entrants. Talk of criminalising failure to deliver care may only drive the offenders deeper into the woodwork. People will be less likely to open up to their faults if they are afraid of being prosecuted. The report talks about rooting out the blame culture, but until that is accomplished, one would always be worried about blowing the whistle. The management may like to describe the situation as "it is no longer a no blame culture but a fair blame" culture - but fair by whose standards, one wonders.

We have a government that has set targets for financial savings for healthcare organisations. The management, unprepared for these challenges, will make changes such as cutting manpower because that is the easiest way to save. Unless the government has a rethink of its financial strategy for the NHS, it is difficult to see how the management will cope with demands. On the other hand, one could argue that a well-qualified management team could identify cost-cutting measures which do not sacrifice quality. The report's recommendation to provide accreditation for management post-holders and holding them more accountable for their performance may encourage individuals with the correct credentials to apply for these posts. Too often, managers in such posts are not specifically trained and tend to learn more on the job.

The Deaneries have been given a chance to influence the environment in which training takes place, and must grab this opportunity to make an impact. It can only be a good thing for trainee doctors to be made aware of their responsibility to report deficiencies in care, as a cultural change started amongst trainees is more likely to produce a next generation of doctors with a conscience – a conscience that will ensure that they act on behalf of their patients.

Far too many organisations exist, and each adds further bureaucratic barriers to the transfer of information. The Francis Report is welcomed as a step in the right direction in highlighting this issue. Particularly welcome is the suggestion to not embark on another re-organisation, but one wonders whether this will be followed.

While all this may be gloomy reading, one needs to very seriously reflect on the finding of the Francis Report that patients were being treated poorly and the medical profession let it happen. We need to be prepared to stand up on behalf of our patients.

The Francis Report is a compelling read, and I would advise every one of you to read it, if you have not done so already.

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