Francis Report

Fault lies with Trust Board that didn't listen to patients or staff but also the whole of the NHS system. There is a system of "checks and balances...a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies" that should have worked together to identify poor care but for years this just did not happen.

Reasons include:

- Culture of focus on business not patients
- More weight on positive information about the service rather than to information that shows something wrong
- Measuring compliance didn't focus on the effect on patients
- High tolerance of poor care and risk
- Failure of communication between agencies
- Assuming monitoring was someone else's job
- Failure to tackle challenge of building a positive culture
- Failure to appreciate loss of experience through repeated reorganisations

Essential recommendations:

- Foster a culture where the patient is put first
- Develop standards that everyone – even the public – can understand and which a breach of will not be tolerated
- Provide compliance standards that are evidence-based and able to be understood and adopted by all staff
- Ensure openness, transparency and candour throughout the system
- Ensure the healthcare regulator focuses on ensuring compliance with the standards
- Make providers accountable and protect the public from those not fit to provide
- Make senior managers and leaders accountable
- Enhance recruitment, education, training and support to all those that provide healthcare, but especially nurses and those in leadership positions
- Develop and share standards that are always being improved with everyone – patients, public, professionals, providers, etc.

Background

The first inquiry heard personal stories about poor care, such as:

- Patients left in soiled bed clothes
- No assistance for patients needing help to eat

- Water out of reach
- Patients not helped with toileting despite requests to do so
- Wards and toilets extremely dirty
- Privacy and dignity denied – even in death
- Triage in A&E done by untrained staff
- Staff treated patients and fellow staff with “callous indifference”

Another key issue was the role of external organisations, including the local HOSC, in failing to recognise that the Trust was having problems. The Terms of Reference for the second review included examining the involvement of the numerous agencies.

Recommendations

There are 290 recommendations. The concern is that, with many other inquiry reports, the recommendations will initially be welcomed but then implementation will be slow or non-existent. The report makes it clear that this should not happen with these recommendations.

The report recommends that:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;
- Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;
- In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations;
- The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.

Summary of Findings

1. Warning signs
During both inquiries there was a constant argument from managers, leaders, regulators, etc that nothing of concern had ever been drawn to their attention. The inquiry found that, on the contrary, the following events could easily have been taken as a sign that all was not well at the Trust:

- Lost of star rating – from three stars to zero. Causes included failure to meet

targets for elective surgery, outpatient waiting times, cancer waiting times and financial performance, of which the SHA was aware. A recovery plan was agreed but the SHA was not overly concerned, thinking the main problem was poor record-keeping.

- Peer reviews – several reviews during 2005 and 2006 identified a number of concerns, some serious, with the Trust's ability to deliver safe care and raised questions about management capability. The issue is that it would appear no one was responsible for following up on peer review reports.
- Healthcare Commission (HCC) – an October 2006 HCC national review of children's service stated the Trust did not meet requirements or reasonable expectations of the public or patients. The Trust responded that this was probably due to a lack of data submitted and that an action plan was developed.
- Auditors' reports – reports identified and reported to the Board serious concerns about the Trust's risk management and assurance systems. The accuracy and reliability of the Trust's compliance with standards was also called into question. These reports should have raised flags about the competency of management at the Trust.
- Surveys – patient and staff surveys conducted on behalf of the HCC rated the Trust as being in the worst performing 20% in the country.
- Whistleblowing – a staff nurse made a serious and substantial allegation about A&E leadership in 2007. This was not resolved by the Trust nor did it make any external agency aware, apart from the Royal College of Nursing, owning solely to its involvement with the nurse.
- Royal College of Surgeons report January 2007 – the report described the Trust's surgical department as "dysfunctional." Again, the report was only known to the Trust and the Royal College: no external agency. Had it been known, it would have showed clear concern to the public or any regulator.
- Trust's financial recovery plan and associated staff cuts – savings in staff costs made when it was already identified as struggling to meet minimum standards. No evidence that any thought was given to the potential effect on patient safety and quality and no questioning of the plans. The SHA also did not question or scrutinise any of the changes.
- Application for FT status – the concerns made apparent by the application had implications about the standard of care being delivered. Senior leadership at the SHA were aware of critical findings but did not consider that a trust with such problems might not be able to deliver safe care. Furthermore, even though Trust management changed there was no sense of urgency from the SHA to make improvements. The HCC remained unaware of the FT status application despite looking into concerns that lead to the first investigation. Monitor was unaware of the HCC's concerns until after the FT application was approved. The HCC regional team was aware of the application but did not communicate this to the Head Office.
- HCC investigation – a formal investigation by the HCC was rare. Other bodies responsible for oversight and regulation awaited the outcome of the investigation, rather than considering for themselves if something needed to

be done.

2. Analysis of Evidence

The Trust and Trust Board

- There was a negative culture at the Trust. The Board and other leaders at the Trust failed to appreciate the enormity of what was happening. There was an ingrained culture of poor standards with a focus on finance and targets.

  "The Trust's culture was one of self-promotion rather than critical analysis and openness... It took false assurance from good news, and yet tolerated or sought to explain away bad news."

- Consultants "kept their heads down" and did not pursue concerns with management.
- There was no culture of listening to patients: there were "inadequate processes for dealing with complaints and serious untoward incidents (SUIs)." Staff and patient surveys showed dissatisfaction but no action was taken.
- There was poor governance and accountability despite this being apparent to the new Chair and Chief Executive in 2004 and 2005.
- Leadership focused on financial issues but not on how this affected service delivery quality.
- There was a shortage of skilled nursing staff but there was not enough done quickly enough to address it. Priority was on ensuring the Trust's books were in order for the FT application.
- "Completely inadequate standard of nursing:" staffing levels, poor leadership, recruitment and training. Incidents went unreported.
- The Trust prioritised finances and the FT application over quality of care.

Voice of the local community

- Patients and relatives felt excluded from participation in patients' care. Patient surveys showed something wrong long before the HCC got involved.
- Community Health Councils (CHCs) provided a good structure for patient and public involvement. The two new replacements over the last 10 years (Patient and Public Involvement Forums (PPIFs) and Local Involvement Networks (LINk)) "failed to produce an improved voice for patients and the public, but achieved the opposite."

  "The relatively representative and professional nature of CHCs was replaced by a system of small, virtually self-selected volunteer groups which were free to represent their own views without having to harvest and communicate the views of others. Neither of the systems which followed was likely to develop the means or the authority to provide an effective channel of communication through which the healthcare system could benefit from the enormous resource of patient and public experience waiting to be exploited."

- The Trust's PPIF achieved nothing "but mutual acrimony between members and between members and the host."

- LINks were “an even greater failure.” Each local authority devised its own working arrangements after the demise of the Commission for Patient and Public Involvement in Health (CPPIH). Squabbling from the previous system was continued under the LINk regime.
- All of this left the public with no effective voice throughout the crisis.
- The report makes clear that with the new Healthwatch there is an inherent risk that it continues the ineffectiveness of some LINks due to the DH not prescribing an operational model, leaving it to local authorities.
- The report also singles out the local authority scrutiny committees. They “did not detect or appreciate the significance of any signs suggesting serious deficiencies of the Trust.” Furthermore, the Inquiry found that there were “a number of weaknesses in the concept of scrutiny, which may mean it will be an unreliable detector of concerns, however capable and conscientious committee members may be.”
- Local MPs received complaints about the Trust but largely passed these on to others without any follow-up or consideration of the implications. While the Inquiry recognises they are not experts in health, it suggests that they may wish to look at how they can increase their ability to recognise problems in local healthcare.

GPs

- Local GPs only expressed concern once the HCC investigation was underway.
- The Inquiry does not blame GPs for failing to spot bad care but nonetheless states that it will be important that they monitor quality in future. They need to be able to recognise patterns of concern and have a responsibility to patients to keep informed on the standards of service available from providers.

PCTs

- PCTs were large organisations with large budgets and staff. They were not initially given the best tools in which to monitor quality and safety standards; rather, as elsewhere, the focus was on financial controls and targets.
- Reorganisations throughout the period meant previous changes had not yet been embedded and meant PCTs were focused on these rather than monitoring performance and quality. While the Inquiry does not blame PCTs for the reorganisations, it no less states that it failed to put in place systems and processes to manage risks as the systems changed.
- There was a continuous assumption that others had responsibility in terms of monitoring quality. Little to no attempt was made to collect quality information systematically.
- Going forward, with the new National Commissioning Board, its regional offices and CCGs, there is a need to ensure commissioning is focused on ensuring standards of service for patients and to identify of the nature of the service to be provided. In order to do this, commissioners must be “recognisable public bodies, visibly acting on behalf of the public they serve.”

SHAs

- SHAs were expected to perform a challenging role through a time of reorganisation, financial challenge and reduction in staff and organisational resources, coupled with a lack of clarity on how they were expected to address concerns about quality and safety.
- The reorganisation in 2005/06 appeared to be conducted without thought to risks to patient safety or quality in doing so. There was also no system of transferring information from one form of SHA to the next.
- The West Midlands SHA had a culture of placing too much trust in provider boards, ready to defend providers rather than consider criticisms and concerns. They also assumed others would share information about concerns without being asked. The SHA was “far too remote from the patients it was there to serve.”
- Going forward, the faults of the SHA are still relevant even though they are being abolished. The report indicates that a performance management and strategic oversight function will still reside in the new system somewhere.

Monitor

- The Inquiry points out that even if the FT application had been refused, it would not have necessary stopped patient suffering before January 2008. But, the regulatory assessment process required by the NHS Act 2006 “ought to have brought those deficiencies to light.”
- The Inquiry has raised strong concerns about the effectiveness of the FT system as a whole. It was warned to be careful of damning the whole system from one extreme case but no less questions how the system could effectively detect patient safety concerns of any significant nature if it could not detect them as severe as they were in this case.
- The report indicates that the “erroneous authorisation” of FT status happened because Monitor and the HCC were separate organisations. They went about their business without coordination. It was not just lack of communication but different, unaligned methods of assessment. The HCC was not tasked to look at finances while Monitor had little clinical resource.

The Healthcare Commission

- The Inquiry indicates that the main failure to detect or prevent the events sooner was the concept of the core standards and the means of assessing compliance: the annual health check (AHC). It claims this suffers from a number of deficiencies.
- The standards were not created by the regulator but by the Government. This meant those looking at the standards interpreted them as Government-controlled and disengaged frontline clinicians from the process.
- Standards included a mixture of general and specific.
- The process was also not good in that it relied on self-assessment and self-declaration. Regulation was on looking at providers’ performance in relation to standards, most of which focused on theoretical systems rather than actual achievements or patient outcomes. The HCC would readily accept

assurances of action from the Trust. The HCC was too passive.

- The boards of regulators are still hired and fired by the Secretary of State despite previous calls for them to be more independent.

Care Quality Commission

- The CQC has had many challenges since its inception: need to merge three organisations, creation and administration of an entirely new system of registration and the monitoring of compliance with a new set of standards. They have also had to take on the regulation of other healthcare sectors and to do it all in a short timescale.
- There is evidence, the report says, that, in setting it up, the strategy has been to fit the activity of the organisation to the resources available.
- The Inquiry has received evidence that the CQC is not “a happy environment to work in.” There is a “defensive institutional instinct” to attack critics. The report says that a regulator needs to be open and welcome criticism.
- The Inquiry believes the new standards are better than what has gone before but still requires improvement; however, it also says that “the current outcomes are over-bureaucratic and fail to separate clearly what is absolutely essential from that which is merely desirable.”
- The Inquiry commends the CQC for its efforts but still has the impression that patient information and feedback are not priorities when looking at an organisation’s performance. It suggests that inspectors ought to be able to look at local complaints and even meet with the complainants.

The General Medical Council and the Nursing and Midwifery Council

- Both are not seen as high profile by the public, therefore no referrals were made about care at the Trust. Professionals as well may have been deterred from making referrals because of the complexity of the process.
- The report states that both organisations should be able to investigate matters of concern even when there isn’t a named individual, but does not believe either is capable of doing so at the moment.

Other external agencies

- The Health Protection Agency was involved with the Trust regarding infection control. It did not escalate any concerns about this area to the HCC or SHA. It also did not volunteer any information to the HCC during its investigation.
- There was a lack of consideration of how important it is for agencies and organisations to share information. “Organisational boundaries and cultures should not prevent the use by all of information and advice designed to enhance patient safety.”
- There is a regulatory gap between the Health & Safety Executive not getting involved in healthcare cases and the CQC refusal to investigate individual cases.
- Gathering patient safety information nationally, as done by the now-abolished National Patient Safety Agency, is welcomed by the Inquiry and further

development insisted upon.

- The Royal College of Nursing was an ineffective professional organisation and trade union at the Trust. The Inquiry found that there may be a conflict of interest between the RCN representing nurses and promoting best practice and standards of care and negotiating terms and conditions of pay and defending members' interests as a trade union.

Department of Health

- While the Inquiry recognises that senior DH officials accept responsibility for and sincere regret for the poor care at the Trust, it also states that the DH "lacks a sufficient unifying theme and direction, with regard to patient safety" even with recent reforms.
- Contributing to the problems at the Trust were the many policy changes occurring during the time. Despite their overall goal of improvement, they were not given time to succeed before a new policy was proposed and implemented. The former Secretary of State admitted that there was often a disconnect between policy decisions being made and practical implementation.
- Structural reorganisations have the potential to destabilise and remove from focus the priority of patient safety and quality.
- The NHS is large and complex, which presents a challenge in focusing on patients. The report indicates that this is only likely to continue as organisations become more autonomous. The DH has the role of ensuring consistency across the NHS.

Why things weren't discovered sooner

One of the main aims of the inquiry was to identify why problems weren't discovered and acted upon sooner. Some of the reasons were:

- The Trust lacked insight and awareness of the reality of what was going on. It was defensive against criticism and not open with patients, the public or external agencies.
- External agency remits were not clearly defined. There were regulatory gaps and a failure to follow up warning signs. Organisations worked in silos and even guarded territories.
- Lack of communication and information sharing across the healthcare system. Lack of openness, transparency and candour.
- Constant reorganisations lead to a loss of corporate memory and confusion about each organisation's function or responsibilities.
- All of this lead to a culture where too much weight was placed on the Trust's assurances or action taken by other regulatory bodies. There was insufficient scrutiny of assurances.
- Performance was all about identifying systems and processes and meeting targets.
- Quality of care and patients were not at the heart of the system for most of the organisations involved: finances and targets were. There was a lack of

engagement with patients and the public. Clinicians were not at the heart of decision-making.

3. Lessons Learned

A common culture

- There must be a "relentless focus" on patients in terms of safety and protection from poor care. There must be no tolerance of poor care. There must be leadership in place to ensure staff are motivated to not accept poor care.
- There must be accessible standards and means of compliance and no tolerance of non- compliance.
- There must be openness, transparency and candour across the system.
- There must be strong leadership in nursing and strong support for leadership roles. There must be a level playing field for accountability.
- There must be accessible information showing performance by individuals, services and organisations.

NHS Constitution

- The NHS Constitution should be the first point of reference for patients and the public and should have included all standards and codes of conduct staff should be expected to follow. It should enshrine patients as the priority.

Simplifying regulation

- The report recommends that the Secretary of State should consider transferring the functions of regulating governance of healthcare providers and fitness of persons to be directors or governors from Monitor to the CQC. It cautions against doing this too quickly or without appropriate planning, to avoid losing expertise at Monitor. It should also not be used a means of saving costs, leading to an under-resourced organisation.

Monitoring of compliance with fundamental standards

- The standards should be policed one regulator: the CQC. It should monitor both compliance with standards and governance and financial sustainability. The CQC shouldn't ensure improvement by the provider but ensure it complies with standards to protect patient safety and quality of care.
- Standards should be set out clearly so that they are understood and accepted by providers, patients and the public. They should not be 'top-down' from Government but should have been consulted on widely, especially to ensure nurses, doctors and patients buy into them.
- Procedures and metrics for policing compliance should be developed by NICE where possible, based on evidence. Help should be sought from the Royal College or third-party organisations if necessary.

Enforcement of compliance with fundamental standards

- The report states that CQC ought to be able to take immediate protective steps to stop a service continuing if there are concerns about its safety.

- Death or serious harm to a patient should enable the provider to be prosecuted under a criminal offence unless the provider can show there was no way of avoiding it.
- Information needs to be shared and complaints should be able to make up this information.
- Inspection should remain the central monitoring tool. There should be a specialist pool of hospital inspectors and consideration given to working with other agencies to inspect and using peer review techniques.

Applying for FT status

- Any application must be preceded by a physical inspection by the CQC. Any organisation found in non-compliance will not be supported in its application.
- Applicants must disclose all relevant information to Monitor in their application, whether it's good or bad. Failure to do so will be subject to criminal sanctions.
- The DH, the NHS Trust Development Authority and Monitor should review the consultation process, to ensure local opinion is captured and provided as evidence of the application.
- The focus of the authorisation process must be on fitness for purpose in delivering quality care and to do so sustainably.

Accountability of board directors and enhancement of governors' role

- Directors should have to comply with a code of conduct. The regulator should be able to make a determination that a person is not fit to be a director, preventing him/her from becoming one at any healthcare organisation.
- The role of FT governors needs to be enhanced, improved and made accountable. The Regulator should publish guidance on what is a proper governor role and what is required to fulfil it. Governors should also be able to be removed if found unfit. They should be provided with training.

Other agencies

- The former National Patient Safety Agency (NPSA) functions regarding incident reporting and analysis need to be continued.
- The HPA information regarding infection control needs to be passed on to the NHS Information Centre. Infection control officials should share concerns with commissioners and regulators when there is cause for concern.

Complaints

- Every trust should have an effective complaints process in place and should take all complaints seriously and respond accordingly.
- The process should be as simple as possible and complaints about potential standards breaches or very serious complaints should be accessible to the CQC, relevant commissioners, health scrutiny committees, communities and local Healthwatch**.**

Commissioning

- Commissioners, as the paying body, need to ensure services are well

provided and provided safely. The commissioner will want to set standards above the CQC bare minimum along with levers for non-compliance.

- Commissioners should set standards for improvement over the longer term. Commissioners should promote improvement.
- The NHS CB should design standards to be incorporated into contracts or assisted local commissioners to design their own.
- All commissioners should be adequately resourced to monitor providers. Commissioners should have access to quality accounts and reports available to the CQC.
- Commissioners should be able to intervene where services are falling down on standards and the CQC should be notified if basic standards are not being met. Contingency plans for providing the service elsewhere or in another way should be drawn up before having to do this.
- Commissioners should decide what needs to be provided, not the provider. They should also consider clinician views, including from providers, GP and procurement expertise to improve their arrangements.
- Commissioners need to raise their public profile so that they can be held accountable and take public views into account.

Local public and patient engagement and partnership

- The report recommends that local authorities pass funds for local Healthwatch to it so that it becomes accountable for the use of the funds. The local authority should then step in if it becomes incapable of performing its functions. There should be a consistent national structure for Healthwatch, along with training and advice.
- Scrutiny committees should have the power to inspect providers, using information from local patient involvement to do so.

Real patient involvement

- The CQC also needs to show that it is an open, honest and transparent organisation. They should look to involve patients in their consultative structure.
- Commissioners should seek public involvement.

Openness, transparency and candour

- The whole system needs to reflect these three qualities in its dealings with patients and the public.
- Organisations need to be completely truthful to regulators.
- There should be no ‘gagging’ orders on staff. There should be no culture of fear.
- The CQC should be responsible for monitoring providers for these qualities.
- Peer review needs to play a key role in delivering and monitoring services.

Caring nurses

- Nursing recruitment, training and education needs to have a focus on compassion and caring. This should be a national standard.
- Nurses should be required to have practical hands-on training and experience. They should never stop learning and being trained.
- Ward managers should be able to supervise and not be bound up in paperwork.
- The NMC should introduce a validation process similar to the GMC.
- Each organisation should have a responsible officer for nursing and he/she should be accountable to the NMC.
- There should be a new status of registered older person's nurse, to reflect the requirements of caring for the elderly.
- There should be at least one nurse on the executive boards of healthcare organisations, including commissioners.

Healthcare support workers

- Healthcare support workers should be subject to a new registration system so that no unregistered person is able to provide direct physical care to patients.
- There should also be a code of conduct for healthcare support workers and the public should be able to easily distinguish between them and nurses.

Leadership

- There should be professional management and leadership training to potential senior staff.
- There should be a code of ethics, standards and conduct for board-level healthcare leaders and managers. Non-compliance can lead to not being a fit director.
- As part of the annual appraisal process, feedback should be sought from patients and families on how well clinicians and nurses show care and compassion.

Proactive professional bodies

- Both the GMC and NMC should have clear policies for when they should be notified of complaints. Both should be more proactive in monitoring fitness to practice.
- Both should work together with the CQC.

Continuing care

- Hospitals should consider nominating one consultant or senior clinician and nurse to be in charge of each patient's care. This ensures families and patients know who is in charge.
- Patients should never be discharged without knowledge that they will be receiving care when they arrive at home. This could include a follow-up visit after discharge.
- GPs should also check on patients after hospital discharge. They should also

monitor patterns of concern which can then be made know to the CQC and commissioner if necessary.

- GPs should feel obliged to ensure their patients know what is the standard of service from providers.

Information

- Information must be available about the performance and outcomes of a service. The public should be able to compare providers.
- Information should be in real time as much as possible. Healthcare professionals should be duty-bound to work together to provide the information.
- Organisations should have a designated board member as a chief information officer.

Reorganisations

- Before any proposal for structural change, an impact and risk assessment should be undertaken by the DH and debated publicly.
- The NHS CB should develop a code of practice to ensure future transitions are planned and managed appropriately.

DH Leadership

- DH should involve senior clinicians in all decisions that may impact on patient safety.
- DH needs to connect more to the NHS and its patients, especially those that have had a poor experience of care. DH should consider a patient consultative forum.

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