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POLICY BRIEFING

The Francis Inquiry into Mid Staffordshire NHS Foundation Trust – messages and implications

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Summary

The Francis Inquiry report attributes accountability for the appalling care at Stafford Hospital to the Trust Board, but also points to a systemic failure by a range of national and local organisations to respond to concerns. The report indicates that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS.

Repeated NHS restructuring was identified as an important element in the background to the failures, and with the most substantial changes to the NHS since its inception now taking place there is clearly potential for further major failings in NHS providers. This policy briefing summarises the report and identifies some significant messages for local authorities in their health responsibilities.

Briefing in full

Background

In June 2010 the then Secretary of State for Health Andrew Lansley charged Robert Francis QC with undertaking a public inquiry into the failures of Mid Staffordshire NHS Foundation Trust. The terms of reference were to:

- examine the operation of commissioning, supervisory, regulatory and other agencies in their monitoring role of Mid Staffordshire NHS Foundation Trust (Stafford Hospital) between January 2005 and March 2009 to identify why problems were not identified and addressed sooner
- identify relevant lessons for how any future failing regimes can be identified as soon as practicable within the context of NHS reforms.

The Francis Inquiry followed a series of investigations and reports, including an investigation by the Healthcare Commission in 2009 and an independent inquiry also conducted by Robert Francis.

The failings at Stafford Hospital have been well reported in the media and will not be repeated in detail here. The number of excess deaths between 2005 and 2008 is

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estimated at 492 people. Examples of poor care include patients being left in soiled bedclothes for lengthy periods, lack of assistance with eating and drinking, filthy wards and toilets, lack of privacy and dignity such as people left naked in a public ward, and triage in A&E undertaken by untrained staff. The report describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'.

The Inquiry looked at the hospital itself and the roles of the main organisations with an oversight role including the Department of Health, the strategic health authority, the PCT, national regulators, other national organisations, local patient and public involvement, and health scrutiny. It made 290 detailed recommendations.

What organisations knew or should have known

Many respondents to the Inquiry indicated that they were not aware of the extent of problems at the hospital and that failings had not been drawn to their attention. The report disagrees with this stance, indicating that clear warning signs were available. These include:

- star ratings reduced from three-star to zero by the Commission for Health Improvement in 2004
- poor peer reviews, auditor reports, and Healthcare Commission reports including staff and patient surveys
- staff concerns reported to management and instances of whistleblowing ignored
- financial recovery plan not consistent with maintaining quality and safety.

The overall picture was that the Trust Board operated with a 'culture of self promotion rather than critical analysis and openness' and that organisations with a role in assessing performance at the hospital all too often accepted the hospital's version of events at face value.

Stafford Hospital

Hospital leaders failed to appreciate the enormity of failings, downplayed their significance, and sought to explain away problems. There was a culture of accepting poor standards and isolation from good practice elsewhere. The leadership prioritised financial issues, meeting targets and achieving foundation trust status rather than quality of care. There was no culture of listening to patients or acting on complaints or poor surveys; information from patients was probably seen as of low importance. Some clinicians raised concerns but did not pursue these 'with vigour' and are described as 'passive'. Evidence to the Inquiry described an environment in which professional staff were in conflict with each other. Clinical governance was not introduced effectively. Due to poor leadership and staffing levels the standard of nursing on some wards was 'completely inadequate'.

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The PCT, GPs and the strategic health authority

The report indicates that at the time PCTs were subject to constant reorganisation and followed national guidance that focused on financial control and access targets. However, PCTs were also under a duty to monitor and improve the quality of services they commissioned and had significant resources. The report indicates that the local PCT experienced a dilemma about potentially destabilising a provider when no alterative provider was available. It criticises the PCT for the time taken to address issues, insufficient focus on developing systems to monitor performance and a willingness to accept that clinical safety was not compromised. Local GPs only expressed 'substantive concern about quality of care' after the announcement of the Healthcare Commission investigation.

The Strategic Health Authority was also operating under extensive financial challenges, organisational restructuring and lack of role clarity. While it did not actively seek out concerns it was willing to intervene if necessary. However all too often it judged concerns as not warranting exceptional action. Overall, it was too ready to trust providers and too remote from patients. The SHA failed to provide information to the DH on the application for foundation trust status and did not consult with the Healthcare Commission.

The report points to the new commissioning systems of NHS Commissioning Board and clinical commissioning groups (CCGs). It indicates that there is an 'urgent need to rebalance and refocus commissioning' on standards of services for patients.

The regulators

Monitor and failure of the foundation trust authorisation process

Monitor is the NHS financial regulator and responsible for foundation trust authorisation. Stafford Hospital was granted foundation trust status in 2008 and the report is swingeing in its criticism of this decision. 'An elaborate, resource-consuming process failed to achieve what should have been its primary objective; ensuring that the only organisations authorised were those with the ability and capacity to deliver services compliant with minimum standards on a consistent and sustainable basis' (Executive Summary 1.51). The report also indicates that there was an 'undue delay' in Monitor intervening when problems were identified. The major factor in the 'erroneous authorisation' was the dissonance between regulation of finance and quality – Monitor and the Healthcare Commission did not co-ordinate their regulatory roles.

The Healthcare Commission

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The report points out that the HC was the regulator at the time of the failings, but it was the first organisation to identify serious concern and take action. It suggests that the top-down design and confusion of the NHS Annual Healthcheck – the process of self-assessment on compliance against standards – contributed to failure to detect problems sooner.

The Care Quality Commission

The report supports the new regulatory model which collects a wide range of information to identify risk of non-compliance. It points to the multitude of organisational challenges the CQC has had to face in a short period of time (merging three organisations, new system of regulation and standards, new registrations). However, it indicates that while the CQC aspires to be an open organisation it has exhibited defensiveness and 'instinct to attack' in the face of criticism. While it is improving and becoming more responsive, it still needs to focus on information from patients.

Professional bodies/regulation

The report describes an inadequate response from organisations including the General Medical Council, the Nursing and Midwifery Council, university/deaneries, the Health Protection Agency, and the Health and Safety Executive. It describes the Royal College of Nursing as 'ineffective both as a professional organisation and a trade union' with failure to uphold professional standards or address problems identified by members. It suggests a potential conflict between its professional and trade union roles.

Department of Health

The report indicates that the DH was genuinely concerned about the failings at Stafford Hospital and has a sincere aim to improve quality for patients. However, over successive governments there have been struggles between rhetoric and implementation. Reforms aimed at improving quality for patients have been imposed too quickly and followed by further reform without being given time to succeed. Clinical leaders were not always at the heart of decision making and officials were sometimes too remote from patients and front-line staff. While it is not fair to say that there is a culture of bullying, action has been interpreted as bullying and instructions may have been applied locally 'in an oppressive manner'.

Voice of the local community

Patient and public involvement

The report identifies that failure to engage with patients and the public is a major factor in the problems at Stafford Hospital. It also indicates that formal patient and

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public involvement mechanisms were not operating well, leaving the campaigning patients' group Cure the NHS as the only effective local voice.

Patient Opinion (a not for profit social enterprise that allows patients and carers to anonymously share their health service experiences in order to receive feedback and improve services) commented on the Francis report that patients themselves need to speak up about their care or nothing will change as a result of the inquiry and that patient stories can make a difference - being an early warning of systemic failings that needs to be urgently redressed. Councils will be interested that a similar scheme will be launched soon for adult social care users and their families.

Most of the respondents to the Inquiry suggested that the organisational model of Community Health Councils, with their mix of officers and board would have been a more effective structure than the models that replaced it.

On Staffordshire Patient and Public Involvement Forum, the report describes 'mutual acrimony' between members and between members and the host, a preoccupation with constitutional and procedural matters and a 'degree of diffidence towards the Trust' as leading to a failure to be effective. Local Involvement Networks (LINks) were described as an 'even greater failure'. 'The albeit unrealised potential for consistency represented by the Commission for Patient and Public Involvement in Health was removed, leaving each local authority to devise its own working arrangements. Not surprisingly, in Stafford the squabbling that had been such a feature of the previous system continued and no constructive work was achieved at all' (Executive Summary 1.22).

On Local Healthwatch (LHW), the report says that without a national framework to provide consistency there is a 'danger of repetition of the arguments that so debilitated Staffordshire LINks'.

Health overview and scrutiny committees (HOSCs)

On health overview and scrutiny, the report says the following. 'The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust. The evidence before the Inquiry exposed a number of weaknesses in the concept of scrutiny, which may mean that it will be an unreliable detector of concerns, however capable and conscientious committee members may be.' (Executive Summary1.25)

Recommendations

The Inquiry makes 290 recommendations of which many are detailed proposals for changes to aspects of policy or process. The overall recommendation is that all organisations involved in NHS commissioning, provision and regulation and 'ancillary organisations' should consider the findings and recommendations of the report. The DH should publish regular reports on how they have responded, and the Commons

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Health Select Committee should consider including this issue in their work programme.

This section presents some of the high profile recommendations and those that relate to the work of local authorities.

- Prioritising the needs of patients in the NHS, with caring, compassionate and committed staff working within a common culture; for example:
  - developing the NHS Constitution so there is greater commitment to staff putting patients before themselves.

- Clear responsibility for, and effectiveness of, healthcare standards and governance, for example:
  - there should be a single regulator dealing with corporate governance, financial competence, viability and compliance with patients' safety and quality standards
  - a merger between Monitor and the CQC should be undertaken incrementally and after thorough planning. CQC would take on responsibility for foundation trust authorisation, incorporating relevant departments from Monitor
  - zero tolerance for failure to meet fundamental standards – organisations who fail should not allow to continue. Criminal liability should follow where serious harm or death results from a breach of fundamental standards
  - any 'wilfully or recklessly false' statement about compliance with safety or essential standards in provider quality accounts should be made a criminal offence.

- Complaints handling should be improved with sensitive, responsive and accurate communication and learning, for example:
  - a facility should be available to Independent Complaints Advocacy advocates and their clients to access expert advice in complicated cases
  - overview and scrutiny committees and LHW should have access to information about complaints (confidentiality maintained).

- Commissioners should incorporate standards and monitor compliance, for example:
  - GPs need to take a monitoring role on behalf of their patients who receive acute hospital or other specialist services
  - commissioners need wherever possible to make available alternative sources of provision
  - greater involvement of patients and the public in commissioning.

- Patient, public and local scrutiny should be improved, for example:

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- there should be a consistent national structure for LHW
- local authorities should be required to pass over their funding allocation for LHW
- respect for the independence of Local Healthwatch should not be allowed to inhibit a local authority – or Healthwatch England as appropriate – intervening
- guidance should be given to promote coordination and cooperation between LHW, health and wellbeing boards and scrutiny committees
- proper training and, where necessary, expert advice should be available to the leadership of LHW
- scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role including easily accessible guidance and benchmarks
- scrutiny committees should have powers to inspect providers rather than relying on patient involvement structures, or should actively work with those structures to trigger and follow up inspections rather than receiving reports without comment or suggestions for action
- MPs are advised to adopt a simple system for identifying trends from individual complaints.

- Greater openness, transparency and candour, for example:
  - a statutory obligation for healthcare providers and professionals to observe a duty of candour
  - criminal liability relating to dishonesty about incidents when informing a regulator or commissioner.

- Nursing – a number of recommendations relating to culture of care and practice, training, national standards and leadership.

- NHS leadership – a number of recommendations relating to training, code of ethics and standards. Serious breaches of the code could result in managers being disqualified from senior positions in future. However, the report falls short of recommending regulation for NHS managers.

- Care for the elderly – there should be specific approaches for older people, such as effective teamwork between disciplines, ward management, and discharge coordination.

Next steps

The fall-out from the Francis report is ongoing. There have been calls, most prominently from Cure the NHS, for the resignation of Sir David Nicholson the NHS

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and NHS Commissioning Board Chief Executive who was previously a strategic health authority chief executive in the West Midlands.

NHS Medical Director Sir Bruce Keogh will investigate five trusts with high death rates. David Cameron has announced that trust boards could be suspended for quality failures as well as financial problems, with a ‘single failure regime’ implemented. He has asked the CQC to create the post of chief inspector of hospitals with a new inspection regime to begin in the autumn. The man who led President Barack Obama’s US healthcare reforms has been engaged to introduce ‘zero-harm’ into the NHS culture. South Tees Hospitals Foundation Trust Chief Executive Tricia Hart and Labour MP Ann Clwyd have been asked to advise on how NHS hospitals should handle patient complaints.

The government will respond to the 290 recommendations in full next month. LGiU will produce a further policy briefing at that time.

Comment

Robert Francis has produced a fair and balanced report which sets the actions of organisations within the context of organisational pressures and limitations. Nevertheless, most organisations involved are criticised for failure to act and there are severe criticisms of the Trust and its leadership. According to Patient Opinion the problems of Stafford Hospital continued for so long and were not identified or fixed by the trust, commissioners or external agencies because no-one was listening.

Local commissioning

One of the key themes is that reorganisation is generally well-meaning but usually undertaken too quickly without adequate planning and without a thorough assessment of the impact on patients and families. ‘Structural reorganisations have made implementing policies for quality and safety very difficult in practice.’ (Executive summary 1.104) Clearly, this message resonates with the current round of restructuring.

The report indicates that any system must have a ‘relentless focus’ on patient safety and quality standards. The role of health and wellbeing boards does not figure prominently in the report, but it would seem that they have an important role in ensuring that local commissioning maintains a focus on quality and safety through difficult financial times.

Merging regulators

Another important recommendation is to merge the CQC and Monitor to plug the gap between their separate roles. Anyone following health policy in recent years will have seen continuing disputes between Monitor and the Healthcare Commission. A

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complete division between economic and quality regulation would seem to inevitably lead to problems. It is disappointing therefore to read in the Health Service Journal that Health Secretary Jeremy Hunt indicates that Monitor will continue as the economic regulator and will probably run the 'single failure regime' for providers announced by the Prime Minister. HSJ further reports that the CQC does not seek to merge with Monitor.

Patient and public involvement

Chapter 6 of Volume 1 of the report provides a detailed account of the development and activity of patient and public involvement at Stafford Hospital. Anyone involved in commissioning or working with LHW will find this an interesting and salutary account.

While it is important not to slide between problems in a specific patient and public involvement mechanism to general comments about the model itself – there are some excellent LINks – there is no doubt that some of the problems identified will be immediately recognisable to anyone involved in developing patient involvement.

One of the dilemmas for local authorities is that intervening in the work of a LINk or LHW as the commissioning organisation may be viewed as oppressive and controlling. For this reason, there has been a reluctance to get involved and a tolerance of poor performance. The report's recommendation that local authorities, or Healthwatch England, should intervene should be built into LHW arrangements.

Also, it is important to recognise that LHW involves people who are volunteers. LHW members need to understand the responsibility of the role they have taken up; the Inquiry report which goes into detail about the action of named individuals should be used as an example for this.

Health overview and scrutiny

Chapter 6 of Volume 1 sets out the role and responsibilities of overview and scrutiny and describes the activity of Stafford Borough Council HOSC and Staffordshire County Council HOSC. Those involved in overview and scrutiny may wish to read this to identify potential lessons.

The role of health scrutiny has been recognised by the Government as effective and important, with increased responsibilities in the NHS reforms. However, scrutiny at Stafford Hospital concerned the specific issue of identifying bad performance, and the dilemmas identified in the report may be familiar to many HOSCs.

Some points that may be of interest to HOSCs can be drawn from the report's conclusions about the role of scrutiny.

- lack of detail in notes in some meetings about Stafford Hospital
- the need to be more proactive in seeking information

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- over-dependency on information from the provider rather than other sources, particularly patients and the public
- lack of resources, particularly in small borough committees
- questions about expertise of some members of HOSCs
- need for clarity in the roles of borough/district and county HOSCs
- scrutiny better conducted at arms-length rather than as a ‘critical friend’.

Finally, the recommendation for scrutiny committees to possibly have inspection powers needs further thought, since it has previously divided opinion in the scrutiny community.

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