NHS Education for Scotland

Board Paper Summary

1. **Title of Paper**

   Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Review of report and its recommendations

2. **Author(s) of Paper**

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3. **Purpose of Paper**

   To provide an Executive Summary (below) and fuller account (attached) of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis, QC

4. **Key Issues**

   The key findings of the Francis Report were as set out below:

   The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis and published on 6th February 2013 examined the interactions of the commissioning, supervisory and regulatory agencies engaged in the monitoring of Mid Staffordshire Hospital between January 2005 and March 2009. It considered why the serious issues at the Trust were not acted upon sooner and sought to determine wider lessons to be learnt from the Stafford experience. This is a very detailed and comprehensive report covering 26 themes and 290 recommendations for action.

   The Trust as an organisation lacked insight and awareness of the deficiencies in care being provided. It was generally defensive and lacked openness with patients, the public and external agencies. The Board focused on financial issues and meeting targets to the detriment of patient safety and the delivery of compassionate, committed care. The non-executive leadership remained aloof from serious operational concerns even when they had obvious strategic significance. Patient and staff complaints were mostly ignored or dismissed. Francis recommends that incidents relevant to patient safety or compliance with fundamental standards be reported and followed up. Staff and patients should be entitled to receive feedback in relation to any complaint they make including information about any action taken or reasons for not acting. Independent
investigation must take place where a complainant raises substantive issues of professional misconduct by a senior manager.

Professional health care regulators should be more proactive in monitoring fitness to practice issues and be equipped to look into systemic problems as well as concerns about individuals. The GMC should amend its standards for medical education to require providers to seek feedback on compliance with minimum standards of patient safety. Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The GMC should consult with inspectorate agencies to develop trainee surveys and routinely share information obtained with healthcare regulators.

The evidence submitted to the Inquiry demonstrated a completely unacceptable standard of nursing care prevalent at the Trust which caused serious suffering for patients and those close to them. The decline in standards was associated with inadequate staffing levels and skills and a lack of effective leadership and support. Health care support workers (HCSWs) constitute a very large proportion of the healthcare workforce and are involved in delivering intimate and sensitive care yet are not subject to any regulatory requirements except for criminal records checks. There is no mandatory training of HCSWs but the work they undertake requires skill and training to be done properly. Francis calls for an increased focus on nurse training, education and professional development and on the practical requirements of delivering compassionate care in addition to the theory. Nurses require support and incentivisation though recognition of achievement, effective supervision and encouragement to give priority to patient wellbeing. Education and training curricula should be reviewed to ensure there are sufficient practical elements of a consistent standard by nursing trainees throughout the country.

The NMC, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates’ attitudes towards caring, compassion and other professional values. Ward nurse managers should operate in a supervisory capacity working alongside staff as role models and mentors, developing clinical competencies and leadership skills within the team. Training and continuing professional development for nurses should also include leadership training at every level from student to director. A registration system should be created for HCSWs and there should be a common set of codes of practice and national standards for their education and training.

The NHS suffers from difficulties in recruiting and retaining leaders of suitable calibre. Good leadership must be visible, receptive, insightful and outward looking with skills shared at all levels of organisations with clinicians engaging in leadership to a far greater extent than hitherto. A common code of ethics, standards and conduct for senior board leaders should be developed and steps taken to make senior managers accountable to the code.

Aspects of a pervasive and deep-rooted negative culture has permeated the health service to give rise to a tolerance of poor standards of care,
defensiveness, misplaced assumptions of trust, secrecy and a failure to put the patient at the forefront of care. Healthcare needs to aspire to a common culture of positive values which recognises transparency, honesty and candour and empowers front-line staff to deliver safe and compassionate care. Such a culture requires the support of strong leadership, mutual support in teams, organisational stability and an improvement-focused agenda. It should be a criminal offence for a director to sign a declaration of belief that the contents of a quality account are true if it contains a misstatement of fact that is known about at the time of signing.

Francis reveals that a combination of factors produced a vacuum in which gross deficiencies in care in Stafford were allowed to exist and persist. The Trust was intent on cost control and pursuing corporate targets rather than on delivery of care, ascribing more weight to positive information than to reports of concern. Insufficient attention was given to the importance of creating good quality learning environments for healthcare trainees with the recommendation that training should not be allowed to take place in settings where patient safety is not being adequately protected. Francis warns against mass reorganisation of the NHS but calls for a set of fundamental standards to be developed in partnership with patients, the public and healthcare groups and adopted by staff who deliver care services. A radical change in culture is required that places quality and the patient perspective at the forefront of care. Healthcare professionals must be truthful to patients and to their employers where harm has or may have been caused and Trusts should be compelled to provide honest and open accounts of their faults and successes.

5. **The Scottish Government Response**

The Scottish Government response to the Francis Report is included in the recently published - *A ROUTE MAP TO THE 2020 VISION FOR HEALTH AND SOCIAL CARE* which sets out 12 Strategic Priorities and the key milestones/deliverables for 2013/14. The key features of the Route Map are that it:

- recognises the importance of the public service reform agenda as a framework for delivering the 2020 Vision;
- maintains the commitment to pursuing the 2020 Vision through a focus on improving quality at scale across Scotland;
- pursues opportunities to work with business partners to drive transformational innovation, providing growth in the Scottish economy;
- identifies particular areas for accelerated improvement;
- supports our commitment to shift the balance of power to, and builds up and on the assets of individuals and communities through working in partnership in CPPs and the new Integrated Health and Social Care Partnerships and
- develops our strategy for engaging and empowering our workforce,
- provides our response in Scotland to addressing many of the issues raised by the Mid-Staffordshire/Francis Inquiry.
6. **The NES Response**

This Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry and its recommendations has been considered by the Executive Team in advance of being placed on the Board agenda. Following the Board consideration of the Report, the Directorates will complete a thorough analysis of the specific issues related to professional training, education and regulation. In addition the Quality Strategy Coordination Group will undertake an analysis from a multi professional and team-based perspective. The Executive Team will then bring together the range of issues pertaining to NES. This collective response can then be brought back to the Board for consideration.

7. **Recommendations**

The Board is asked to consider the following:

1) Consider the findings of the Francis Report and the possible arenas where further discussion and action are required.
2) Note the Scottish Government response to the Francis Report.
3) Endorse the NES process for developing a response to Francis, with reference to workforce development, education, training and regulation.

NES
HA/BD
April 2013
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry:  
Review of report and its recommendations

The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC was published on 6th February 2013. This built on the report of a previous independent inquiry (February 2010) which focused primarily on internal operations and personal accounts from patients and their families in respect of the appalling care received at the Trust. The second inquiry was set up to examine the interactions between the Trust and the various agencies responsible for oversight, commissioning and regulation of healthcare services and professional groups of staff between January 2005 and March 2009.

This inquiry also sought to identify wider lessons to be learnt from the Stafford experience and emphasises the need to safeguard patients from unacceptable and unsafe care in the future. The report itself is long and extremely comprehensive comprising three large volumes of evidence and analysis and recommendations for action, an executive summary (83 pages) accompanied by a table listing all 290 recommendations, a chairman’s statement (9 pages) and a short paper on key facts and figures. There are 26 themes covered in the report whilst the executive summary condenses information into three categories: warning signs, analysis of evidence and lessons learned with related recommendations. Collectively the recommendations call for a fundamental shift to a person-centred culture throughout the healthcare system with greater cohesion and staff engagement to effect a safer, committed and compassionate caring service for patients and their families.

Analysis of the main findings of the report has sought to make sense of the extent and range of evidence and recommendations presented in the context of our work as a special health board predominantly responsible for education and training. As such not all themes are covered particularly those that focus on the funding and monitoring arrangements for the NHS in England. Francis’ diagnoses of the faults have been set out in the order as they appear in the report along with his recommendations for their remedy. A concluding section highlights some of the key generic findings for consideration and the impact they may have on our work.

Key themes

Warning signs
- Evidence revealed numerous and in several cases serious causes for concern about the Mid Staffordshire NHS Foundation Trust’s standard of service, governance, finances and staffing for many years prior to the first and second inquiry.
- These concerns whilst reported were never addressed effectively
- These concerns had implications in relation to patient safety and the Trust’s ability to deliver a minimum acceptable standard of care.
The Trust
- Dissatisfaction with the leadership of the Trust, the CEO and Chair was being expressed from 2001 although this did not result in a change of CEO until 2005 when Martin Yeates was appointed.
- The Trust Board leadership between 2006 and 2009 lacked experience, had great self-confidence, and focused on financial issues, obtaining foundation trust (FT) status and meeting targets. They lacked insight into the impact of their decisions on patient care.
- The non-executive leadership remained aloof from serious operational concerns even when they had obvious strategic significance.
- The clinical executive leadership did not have a strong professional voice. The medical profession remained largely disengaged from management and did not pursue their concerns effectively.
- There was a culture of tolerance of poor practice, denial of the significance of concerning mortality figures and of patient complaints, and a lack of openness.
- The focus on finance led to staffing cuts made without any adequate assessment of their effect on care or operational effectiveness.
- Patient and staff complaints were ignored or dismissed.

Recommendations
- Reporting of incidents relevant to patient safety, compliance with fundamental standards must be insisted upon. Staff are entitled to receive feedback in relation to any report they make including information about any action taken or reasons for not acting.
- Healthcare organisations should use evidence-based tools to measure not only clinical outcomes but the suitability and competence of staff and the cultural environments of healthcare workplaces.

Complaints, process and support
- There was a reluctance by patients and those close to them to complain in part because of fear of the consequences and other organisational barriers.
- There needs to be adequate support and advocacy in place for complainants.
- The feedback, learning and warning signals available from complaints were not given a high enough priority.

Recommendations
- Methods of registering a comment or complaint must be readily accessible and easily understood.
- Organisations must constantly promote their desire to receive and learn from comments and complaints.
- Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.
- Arms-length independent investigation of a complaint should be initiated where a complaint raises substantive issues of professional misconduct or the performance of senior managers.
Patient and public involvement and scrutiny

- Patient and public involvement received little proper support or guidance.
- The mechanisms for patient and public involvement raised expectations about their role but relied on enthusiastic but uninformed and untrained volunteers from a small, unrepresentative pool of the ‘usual suspects’.
- The role of the local media in highlighting problems in quality should not be ignored as a warning sign.
- There is a danger that local scrutiny which is in fact ineffective may appear to offer false comfort to regulators.

Recommendations

- Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.
- There should be more effective coordination and cooperation between local health and wellbeing agencies and local government scrutiny committees.
- Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate.

Professional regulation

- The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) were largely reactive to individual complaints against identifiable individuals which may suggest unfitness to practise on the part of doctors and nurses.
- Stafford demonstrated a lack of referrals by professionals to their regulators when concerns were raised.
- The Trust failed to have a proper policy for referring clinicians to professional regulators.
- The NMC and the GMC need to develop a close working relationship with the Care Quality Commission (CQC).
- Patients are often not aware of the existence and procedure for complaining to the NMC and the GMC.
- Doctors were reluctant to accept standard processes and to engage with team and management roles.

Recommendations

- The GMC should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.
- If the GMC is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the CQC and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information.
- To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the NMC needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems
regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures.

- The NMC needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It must be empowered to act on its own if it considers it necessary in the public interest.

- It is highly desirable that the NMC introduces a system of revalidation similar to that of the GMC as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public.

- The profile of the NMC needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses.

**Medical Training**

- The quality assurance and management documentation seen by the Inquiry did not demonstrate an adequate recognition of the role medical education and training activity can play in safeguarding patients or of the importance of training taking place in environments not complying with minimum safety and quality standards.

- Since the events at Stafford, the GMC has taken encouraging steps to increase the focus on patient safety, including a specific question in its trainee survey, the creation of a response to concerns process and an audit of emergency department rotas.

- The GMC has a justifiable concern in relation to the safety of patients that European Economic Area (EEA) practitioners do not have to demonstrate proficiency in English. There appears to be no reason why such a requirement could not be imposed on all candidates for registration.

- The GMC’s assessment of Approved Practice Settings relied on the results of the Healthcare Commission’s Annual Health Check ratings.

- Surveys of the type administered by the Postgraduate Medical Education and Training Board suffered from a number of disadvantages resulting in it being less likely that concerns would be exposed, and they need development to exploit the information about standards of service likely to be known to trainers and trainees.

- Self-assessments provided by the Trust to the deanery failed to disclose the true state of affairs.

- The system for reporting deanery visits to the Trust did not give sufficient weight to concerns raised by trainees with regard to their relevance to patient safety.

- The Deanery organised a degree of rigorous supervision in response to Dr Turner’s complaints about the Trust’s Accident and Emergency (A&E) but the Dean took no personal steps to liaise about these with the HCC after becoming aware of its investigation.

**Recommendations**

- Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the
acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.

- Information sharing between the deanery, commissioners, the GMC, the CQC and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities.

- The CQC and Monitor should develop practices and procedures with training regulators and bodies responsible for the commissioning and oversight of medical training to coordinate their oversight of healthcare organisations which provide regulated training.

- The GMC should set out a standard requirement for routine visits to each local education provider, and programme in accordance with the following principles:
  - The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions.
  - The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required.
  - There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority.
  - Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of the CQC and other forms of review.
  - The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out.
  - All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional development and dissemination of good practice are of significant value.

- The GMC should set out a clear statement of what matters; deaneries are required to report to the GMC either routinely or as they arise. Reports should include a description of all relevant activity and findings and not be limited to exceptional matters of perceived non-compliance with standards. Without a compelling and recorded reason, no professional in a training organisation interviewed by a regulator in the course of an investigation should be bound by a requirement of confidentiality not to report the existence of an investigation, and the concerns raised by or to the investigation with his own organisation.

- The GMC should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.

- Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The GMC should consult the CQC in developing the survey and routinely share information obtained with healthcare regulators.

- Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.
Department of Health (DH)

- In general of the report has been to consider the actions of the DH collectively rather than on the basis of the responsibility of individual civil servants. Over time there has been an increasing recognition of the importance of articulating and defining the requirements of quality and safety, but the shift in culture to make aspiration a reality has yet to be completed.

- There has been recognition that there is a problem with the standard of nursing care but the problem persists in spite of various DH initiatives.

- The aspiration of commissioning to drive quality improvements as a theoretical concept was implemented before the structure and resources were in place to make it an effective reality.

Recommendations

- Impact and risk assessments should be made public, and debated publicly, before a proposal for any major structural change to the healthcare system is accepted.

- The DH should together with healthcare systems regulators take the lead in developing, through obtaining consensus between the public and healthcare professionals, a coherent, and easily accessible structure for the development and implementation of values, fundamental, enhanced and developmental standards.

- The DH should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being. The DH needs to connect more to the NHS by visits, and by personal contact with those who have suffered poor experiences.

Culture

- The challenge for the system is to identify a means of ensuring a common culture of positive values and methods prevailing over, and driving out, negative values and methods.

- The system requires a common positive safety culture. That is, one which aspires to cause no harm to patients and to provide adequate and where possible, excellent care and a common culture of caring, commitment and compassion.

- Aspects of a negative culture have emerged at all levels of the NHS system. These include: a lack of consideration of risks to patients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions of trust, acceptance of poor standards and, above all, a failure to put the patient first in everything done. The emergence of such attitudes in otherwise caring and conscientious people may be a mechanism to cope with immense difficulties and challenges thrown up by their working lives.

- A shared positive safety culture requires: shared values in which the patient is the priority; zero tolerance of substandard care; empowering front-line staff with the responsibility and freedom to deliver safe care; recognising them for their contribution; and that professional responsibility is accepted and pursued.

- Such a culture requires the support of strong and stable cultural leadership, mutual support in teams, organisational stability, useful comparable data on outcomes, and expectations of openness, candour and honesty.
- A positive safety culture at front-line level could be evidenced by thorough and thoughtful information provided to patients, clear identification of staff and their roles, open and receptive staff interaction with patients and visitors, meticulous attention to cleanliness, hygiene, nutrition and hydration of patients, production of and adherence to standard procedures, and insistence on proper discharge arrangements.

- Leaders of organisations must not only require others to adopt the shared culture, they must do so themselves and be seen to do so. This involves measures such as: open board meetings, personally listening to complaints, and an open and honest admission where there is an inability to offer a service. At a system level it has to be shown constantly how the well-being of patients is protected or improved by measures proposed.

**Recommendations**

- The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority. This requires:
  - A common set of core values and standards shared throughout the system;
  - Leadership at all levels from ward to the top of the DH, committed to and capable of involving all staff with those values and standards;
  - A system which recognises and applies the values of transparency, honesty and candour;
  - Freely available, useful, reliable and full information on attainment of the values and standards;
  - A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.

- Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.

**Values and standards**

- There needs to be a common statement of values to which all staff groups can commit together. The NHS Constitution is intended to be a common source of values and principles and should become the common reference point for all staff.

- A structure of standards should be provided with improved clarity of status and purpose by distinguishing between fundamental safety and essential care standards formulated by regulation, enhanced standards of quality formulated by the NHS Commissioning Board, and discretionary developmental standards formulated by commissioners and providers.

- Indicators of compliance with fundamental standards should be set by CQC. NICE should be commissioned to formulate standard procedures and guidance designed to provide practical means of compliance.
Formulation of any standard needs to be “owned” by patients and front line professionals: full involvement of patient groups and professional bodies in the formulation of all standards as well as the methods and measurement of compliance is vital. Accurate information about compliance and non-compliance, capable of comparing individuals, services and providers, must be readily accessible to all.

Recommendations

- The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system’s common values, as well as the respective rights, legitimate expectations and obligations of patients. The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos. The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including a Code of Conduct for NHS Managers.
- All NHS staff should be required to enter into an express commitment to abide by the NHS values and the constitution, both of which should be incorporated into the contracts of employment.
- Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well.
- It is essential that professional bodies in which doctors and nurses have confidence are fully involved in the formulation of standards and in the means of measuring compliance.
- NICE should be commissioned to formulate standard procedures and practice designed to provide the practical means of compliance, and indicators by which compliance with both fundamental and enhanced standards can be measured. These measures should include both outcome and process based measures, and should as far as possible build on information already available within the system or on readily observable behaviour.
- Zero tolerance: A service incapable of meeting fundamental standards should not be permitted to continue. Breach should result in regulatory and possibly legal consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible.

Openness, transparency and candour

- Openness, transparency and candour are necessary attributes of organisations providing healthcare services to the public.
- The Trust made inaccurate statements about its mortality rates, information about serious concerns was not passed to the regulator, and a report critical of the care provided was not disclosed to the coroner. Frank and accurate information about the cause of death of patients was not universally conveyed to relatives. Exaggerated claims of success were made to the public.
- There is a requirement not only for clinicians to be candid with patients about avoidable harm, but for safety concerns to be reported openly and truthfully,
and for organisations to be accurate, candid and not provide misleading information to the public, regulators and commissioners.

- Current requirements for openness, transparency and candour do not cover uniformly and consistently the areas in which these are needed.

Recommendations

- Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.
- A statutory obligation should be imposed to observe a duty of candour:
  - On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request;
  - On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable.
- It should be made a criminal offence for any registered medical practitioner, or nurse, or AHP or director of an authorised or registered healthcare organisation:
  - Knowingly to obstruct another in the performance of statutory duties;
  - To provide information to a patient or relative intending to mislead them about such an incident;
  - Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.
- “Gagging clauses” or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.

Nursing (and Health Care Support Workers)

- The evidence showed that a completely unacceptable standard of nursing care was prevalent at the Trust and that this caused serious suffering for patients and those close to them.
- The decline in standards was associated with inadequate staffing levels and skills, and a lack of effective leadership and support.
- Nursing staff at the Trust did not receive effective support or representation from the Royal College of Nursing (RCN).
- The aptitude and commitment of candidates for entry into nursing to provide compassionate basic hands-on care to patients should be tested by a minimum period of work experience, by aptitude testing and by nationally consistent practical training. Effective support and professional development for nurses should be made the responsibility of professionally accountable responsible officers for nursing, and, in due course, reinforced by a system of
• The capacity for front-line nursing leadership needs to be increased by better support and professional development resources, by placing leaders at the centre of teams caring for patients, and by identifying nurses with personal responsibility for each patient.

• The leadership required for the delivery of excellent nursing care should be recognised and incentivised in the remuneration structure by more explicit reference to the delivery of excellent care, and by use of professionally formulated and accepted performance measures.

• The specialist skills, commitment and compassion needed for the nursing care of the elderly should be accorded the recognition they deserve by creation of a specialist registered status.

• There is an inherent conflict between the professional representative and trade union functions of the RCN which may diminish the authority of its voice on professional issues.

• Health care support workers (HCSWs) constitute a very large proportion of the healthcare workforce and are involved in delivering intimate and sensitive care yet are not subject to any regulatory or other standard requirements except for criminal records checks.

• There is no mandatory training of health care support workers (HCSWs) but the work they undertake requires skills and training to be done properly.

Recommendations

• There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires selection of recruits to the profession who evidence the:
  - Possession of the appropriate values, attitudes and behaviours;
  - Ability and motivation to enable them to put the welfare of others above their own interests;
  - Drive to maintain, develop and improve their own standards and abilities;
  - Intellectual achievements to enable them to acquire through training the necessary technical skills;

Other standards of nursing include:
  - Training and experience in delivery of compassionate care;
  - Leadership which reinforces values and standards of compassionate care.

• Constant support and incentivisation of nursing through: Recognition of achievement; regular, comprehensive feedback on performance and concerns; encouragement to report concerns and give priority to patient well-being.

• Nursing training should be reviewed so that there are sufficient practical elements to ensure achievement of a consistent standard by trainees throughout the country. This requires national standards.

• There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. An alternative would be to require candidates to
undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.

- The NMC, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates’ attitudes towards caring, compassion and other necessary professional values.
- The NMC and other professional and academic bodies should work towards a common qualification assessment/examination.
- There should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care.
- Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates’ values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.
- As part of a mandatory annual performance appraisal, each nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation.
- Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.
- Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.
- Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology.
- Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient.
- Consideration should be given to the creation of a status of Registered Older Person’s Nurse.
- There should be a uniform description of HCSWs, with the relationship with currently registered nurses made clear by the title.
- A registration system should be created for HCSWs wherever they work and there should be a common set of codes of practice and national standards for their education and training.
Leadership in healthcare

- The NHS suffers from difficulties in recruiting and retaining leaders of suitable calibre.
- Good leadership must be visible, receptive, insightful and outward looking. Leadership and managerial skills are not the same but both are required.
- Leadership skills are required to be shared at all levels in an organisation, from board to ward, and all staff must be empowered to use their own judgement in providing the best possible care for patients.
- Clinicians must be engaged to a far greater degree of engagement in leadership and management roles. The gulf between clinicians and management needs to be closed.

Recommendations

- A leadership staff college or training system, whether centralised or regional, should be created to: provide common professional training in management and leadership to potential senior staff; promote healthcare leadership and management as a profession; administer an accreditation scheme to enhance eligibility for consideration for such roles; promote and research best leadership practice in healthcare.
- A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.
- Senior managers should be made accountable.

Common culture applied

- There should be clear identification of responsibility for each patient’s care, led by a named consultant.
- There should be clear nursing responsibilities for each patient’s care and a clear dual responsibility at the point of handover.
- The experience of Stafford demonstrates the importance of constantly ensuring patients receive proper food and nutrition.
- Teamwork is vital and the contribution of all individuals in the team needs to be recognised and encouraged.
- There needs to be good communication with and about the patient, with appropriate sharing of information with relatives and supporters.
- The importance of the involvement of patient families and carers should be recognised by those caring for patients.

Recommendations

- There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.
- Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds.
- All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.
All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.

**Information**
- The effective collection, analysis and dissemination of relevant information is essential for swift identification and prevention of substandard service and facilitating accountability.
- Healthcare professionals and organisations, individually and collectively, must commit themselves to identifying with patients and the public, and introducing measures that fairly reflect their performance.
- Quality accounts provide a vehicle to provide consistent and comparable information about compliance with standards and other requirements, but there is room for improvement by attention to consistency of presentation, balance in reporting of positive and negative results, and rigorous auditing.
- It was generally accepted that failure to share relevant information lay at the heart of the failure of the system to detect the scale of the deficiencies at the Trust and that an effective overall system of information is essential.

**Recommendations**
- It should be a criminal offence for a director to sign a declaration of belief that the contents of a quality account are true if it contains a misstatement of fact concerning an item of information which he/she does not have reason to believe is true at the time of making the declaration.
- It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.
- The information behind the quality and risk profile, as well as the ratings and methodology, should be placed in the public domain together with appropriate explanations to enable the public to understand the limitations of the tool.

**Conclusion**

Francis’ report of the public inquiry reveals that a combination of factors and deficiencies within a complex web of healthcare providers, commissioners and regulators produced the vacuum in Stafford in which gross deficiencies in care were allowed to exist and persist. In examining what went wrong, however, he maintains that searching for scapegoats will be a limited, even a dangerous, undertaking:

“To place too much emphasis on individual blame is to risk perpetuating the illusion that removal of particular individuals is all that is necessary...To do this would be to create a fiction that the behaviour of one person, or a small group of people, would have made all the difference and conclude the easy answer to the problem is to appoint better performing individuals. It was not a single rogue healthcare professional who delivered poor care in Stafford, or a single manager who ignored patient safety, who caused the extensive failure which has been identified”

p.36 Executive Summary
Instead, Francis points to a pervasive and deep-rooted negative culture within the health service that prevented staff from speaking up and barred patients and their families from being heard. The organisation was intent on “the system’s business (corporate self interest and cost control) – not that of the patients” and ascribed much more weight to positive information about its services than to any reports of concern.

He also warns against further mass reorganisation of the NHS. Healthcare, he insists, is not an area or activity short of systems and agencies intended to improve standards, regulate the conduct of its staff and report and scrutinise performance. As such it is striking that there was no proper degree of accountability taken by the Board or senior managers or health professionals at Mid Staffordshire and an assumption that monitoring, performance management and intervention was someone else’s responsibility. Amongst the litany of failures Francis identified, was the reluctance of many healthcare agencies to openly and proactively share information and knowledge of their concerns. There was a fundamental lack of openness, transparency and candour in the reports generated by the Trust and an over-reliance on the positive responses of others.

Insufficient attention was given to the importance of creating good quality learning environments for healthcare trainees with the recommendation that training should not be allowed to take place in settings where patient safety is not being adequately protected. There was widespread evidence of professional disengagement and passivity shown by senior clinicians who were not at the heart of decision-making on care issues. When concerns were raised by staff about inappropriate pressure or bullying behaviour, these allegations were seldom followed up or investigated. As a result of poor leadership and staffing polices, a completely inadequate standard of nursing was offered on some wards at Stafford. The complaints heard at both inquiries testified not only to persistent, inadequate staffing levels but also to poor recruitment and training and a tolerance of poor standards of care.

The extent of the failures is such that in Francis’s analysis only a radical change in culture will suffice, one that collectively places quality and the patient perspective at the forefront of care. He recommends that a set of fundamental standards be developed in partnership with patients, the public and healthcare groups and adopted by staff who deliver care services. Non compliance with these duties leading to serious harm or death should be a criminal offence. Healthcare professionals must be truthful to patients and to their employers where harm has or may have been caused and Trusts should be compelled to provide honest and open accounts of their faults and successes.

The recruitment, education, training and support of all healthcare groups but particularly those in nursing and leadership positions should be enhanced to ensure delivery of a compassionate and caring service. Recruits to nursing ought to be assessed for their aptitude to deliver and lead proper care and their ability to commit themselves to the welfare of patients. Nursing needs a stronger professional voice including representation in organisational leadership and encouragement of leadership at ward level. The regulation of healthcare support workers including development of national standards for education and training were also key recommendations.
Francis’ detailed report covers over one million pages of documentary evidence with 290 recommendations for action. Collectively the recommendations call for a fundamental shift to a person-centred culture throughout the healthcare system with greater cohesion and regulation to effect a safer, committed and compassionate caring service for patients and their families. Yet his call for greater transparency and partnership seems at odds with the recommended tightening of system controls and accountabilities. Cultural change will not come about by mandate but through staff engagement and reciprocity and by leaders being able to build and maintain constructive relationships. Whilst the Francis recommendations represent powerful tools for improvement, they are not a panacea and will not necessarily prevent a repetition of failures in care in the future. Indeed, they could themselves create their own pressures, tensions and difficulties and the cultural change needed to deliver them is going to take long-term, profound and sustained work.

Helen Allbutt
February 2013
Appendix 1: Presentation of themes in the final report omitted from this review:
The Foundation Trust authorisation process

Mortality statistics

Commissioning and the Primary Care Trust

Performance management and the Strategic Health Authorities

Regulation: the Healthcare Commission

Regulation: Monitor

Regulation: the Care Quality Commission

Regulation: the Health and Safety Executive

Certification and requests relating to hospital deaths

Risk Management and the NHS litigation

Health Protection Agency

National Patient Safety Agency