The Francis report: a summary for HFMA members

Robert Francis called for fundamental change in the NHS in his report into the failings at Mid Staffordshire NHS Foundation Trust, published on 6 February.

In his covering letter to the health secretary, the QC said the story his report told was ‘first and foremost of appalling suffering of many patients’ between 2005 and 2009. He said this was primarily caused by the failure of the trust board to listen to patients’ concerns, correct deficiencies and tackle an ‘insidious negative culture’ that tolerated poor standards and clinical disengagement from managerial and leadership responsibilities.

‘This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable standards of care,’ he added.

While the trust had financial problems during the period addressed by the inquiry, the trust board and the wider NHS did not regard these as particularly remarkable, Mr Francis said. However, he continued: ‘I have no doubt that the economies imposed by the trust board, year after year, had a profound effect on the organisation’s ability to deliver a safe and effective service.’

The report said the trust has prioritised its FT application over standards of patient care. An internal review addressing the shortage of skilled nursing staff progressed slowly – this was due to the priority given to promoting a healthy financial picture in order to achieve foundation status. Mr Francis said the system as a whole appeared to pay lip service to the need not to compromise services and quality, but it was ‘remarkable’ how little attention was paid to the impact of proposed savings.

While it did not criticise individuals, the report identified systemic failings at every level. For example, the Department of Health and strategic health

authority were too remote from the services being delivered; primary care trusts did not have the capacity to ensure they were buying quality services; local clinicians did not raise concerns until it was too late; and patients' concerns were not heard or ignored.

It said there was no evidence the trust or SHA had considered the impact that staff reductions – identified as part of the trust's financial recovery plan – would have on safety and quality.

The report said the foundation trust application process focused largely on finance and governance, but Monitor was not aware of Healthcare Commission concerns about the trust until after it had been authorised as an FT. The then health secretary was not given adequate information in the lead-up to giving his support to the trust's application for foundation status.

Mr Francis said that despite multiple checks and balances, early warning signs were not picked up. A number of factors caused this, including:

- A culture of 'doing the system's business' rather than focusing on patients;
- More weight being given to positive news about the NHS than to information that could cause concern
- Compliance measures that failed to focus on the effect of a service on patients
- Tolerance of poor standards and risk to patients
- A failure of agencies to communicate and share concerns
- Until recently there had been little appreciation of the loss of corporate memory caused by reorganisation.

Recommendations

Mr Francis made 290 recommendations that he said would ensure 'self interest and cost control' were not put ahead of patients' interests. He said they fell into five main categories:

1. Fundamental standards and measures of compliance

- Develop a list of fundamental standards that must be met to permit any hospital service to continue
- Causing death or serious harm to a patient through non compliance without reasonable excuse should be a criminal offence
- The National Institute for Health and Clinical Excellence should produce standard procedures and guidance on complying with the fundamental standards. These should include evidence-based tools for establishing the staffing needs of each service
- The standards should be policed by the Care Quality Commission (CQC)
- There should be a single regulator for corporate governance, financial competence, viability and care quality. Monitor's responsibilities for FT authorisation, governance, financial sustainability and the fitness of directors, governors and equivalent senior officials should be transferred to the CQC
- The NHS Litigation Authority should set more demanding levels of financial incentives in its risk management ratings to motivate trusts to reach level 3. There should be more effective sharing and recording of information
- FT applicants should have to demonstrate they meet fundamental safety and quality standards, as well as the financial and governance requirements

2. Openness and candour

- There should be a statutory duty to be truthful to patients where harm has or may have been caused
- Staff should have a statutory duty to make their employers aware of such incidents
- Trusts should be open and honest in their quality accounts, describing faults as well as successes. Deliberate obstruction of meeting these duties or deliberate deception of patients should be a criminal offence
- It should be a criminal offence for trust directors to deliberately give misleading information to the public and regulators

- The CQC should be responsible for policing these duties

3. Improved support for compassionate, caring and committed nursing

- Entrants to nursing should be assessed for their aptitude to deliver and lead proper care and their commitment to patient welfare
- Training standards must be developed to ensure qualified nurses can deliver compassionate care to a consistent level
- Nurses should be given a stronger voice in leadership at organisation and ward level
- All healthcare support workers should be regulated by a registration scheme

4. Stronger healthcare leadership

- An NHS leadership college should be established to ensure there is a common culture, code of ethics and conduct among all current and potential future leaders. A leadership college accreditation scheme should be considered
- A code of ethics for all senior staff should be produced, but apply to all NHS staff.
- There should be a fit and proper person test for NHS directors. Being guilty of a serious breach of the code of conduct should lead to disqualification from holding senior positions in the NHS
- While registration could be performed by an existing regulator, the need for a separate entity should be kept under review. The need for such a management regulator would be informed by experience of the fit and proper persons test

5. Information

- The public should be able to compare relative performance in providers' compliance with standards
- All healthcare providers should develop and publish real time information on the performance of consultants and specialist teams in relation to mortality, morbidity, outcomes and patient satisfaction

- Every provider should have a designated board member as chief information officer

Click here for the full report and here for the executive summary

Government reaction

In a statement in the Commons following publication of the report, prime minister David Cameron apologised to patients and their families for the system failures that allowed the 'horrific abuse' to go on for so long. The government would study the recommendations and respond in detail in March.

However, he believed immediate progress could be made in three areas:

Patient care As previously announced the government will introduce the 'friends and family' test for every patient, carer and member of staff. Serious concerns will lead to an immediate inspection and potentially the suspension of the trust board.
US health quality leader Don Berwick has been called in to advise on how to make zero harm to patients a reality across the NHS.
Nurses should be hired and promoted on 'the basis of having compassion as a vocation' as well as academic qualifications. Mr Cameron raised the issue of whether pay should be linked to quality of care rather than just time served in the NHS.

Accountability The Nursing and Midwifery Council (NMC) and General Medical Council will be asked to explain why no-one has been struck off so far. The Law Commission will advise on changing the NMC's decision making process.

The Health and Safety Executive has been asked why it decided not to prosecute in some cases – the government will look at whether the HSE right to conduct criminal prosecutions should be transferred to the CQC.

Complacency A new chief inspector of hospitals post will be created by the CQC. They will be responsible for a new inspection regime similar to that in schools. This will start in the autumn.
NHS medical director Sir Bruce Keogh will conduct an immediate investigation into hospitals with the highest mortality rates.