RCGP Summary
The Francis Report, February 2013

Overview

Published on Wednesday 6th February 2013, the final report of the Francis Inquiry into failures of care at Mid Staffordshire NHS Foundation Trust has profound implications for the whole of the NHS.

Part A of this summary provides RCGP members with an overview of the report's key findings. Whilst much of the report focuses on secondary care, **Part B** of this document summarises findings that relate more directly to general practice and primary care.

Further resources

- Access an online version of the full Francis Report.
- Read the RCGP's press statement in response to the publication of the report (also included as an annex to this document).
- Further information and guidance on NHS 'whistle blowing' and an accompanying policy statement is available on the RCGP website.

Part A - Overview of the Francis Report

The Francis report is the result of a public inquiry into the role of commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust between January 2005 and March 2009. It follows on from two previous inquiries into events at the Trust which uncovered a lack of basic care in many of its wards and departments. This previous report brought to light many distressing personal accounts of appalling care, such as patients being left in excrement in soiled bed clothes for lengthy periods, assistance not being provided with feeding for patients who could not eat without help, and staff treating patients and their families with indifference and a lack of basic kindness.

This report considers why these serious problems at the Trust were not identified and acted on sooner, and what should be done to prevent it happening again in future. Its findings are highly critical of the Trust's Board at the time highlighting "an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities". However, the report ultimately concludes that responsibility is not confined to the Board of the Trust alone, but runs right through the health service. It states that events at the Trust are "not… of such rarity or improbability that it would be safe to assume that it has not been and will not be repeated".

The report calls for a "fundamental change" in culture whereby patients are put first and makes 290 recommendations covering a broad range of issues relating to patient care and safety in the NHS.

Key recommendations from the report include:

- The introduction of a new statutory '**Duty of Candour'** requiring all NHS staff and directors to be open and honest when mistakes happen. If implemented, this will this will place a legal obligation on health service provider organisations and individual practitioners to be honest, open and truthful in all their dealings with patients and the public. The report states that provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.

- The establishment of a **single regulator for financial and care quality** dealing with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts.

- More **powers to suspend or prosecute boards and individuals** should standards of care not be maintained. Breach should result in regulatory consequences, attributable to an organisation in the case of a system failure, and in individual accountability where individual professionals are responsible. There should be criminal liability where serious harm or death has resulted to a patient due to a breach of the fundamental standards, that the report proposed should be introduced.

- **Banning gagging clauses** or non-disparagement clauses as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.

- **Only registered people should care for patients.** A registration system should be created under which no unregistered person should be permitted to provide direct physical care to patients in a hospital or care home setting. The system should apply to healthcare support workers. This approach is applicable to all patients but requires special attention for the elderly.

- Hospitals should **review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case**, so that patients and their supporters are clear who is in overall charge of a patient's care.

- **Directors should be subject to a new fit and proper person test.** Such a test should include a requirement to comply with a prescribed code of conduct for directors.

- **Complaints should be published on hospital websites** alongside the trust's response.

- **GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. (See Part B for more on the role of GPs)**

- **Local authorities should be required to pass over the centrally provided funds allocated to its local Healthwatch** (the new "consumer champion" body for healthcare), while requiring the latter to account to it for its stewardship of the money.

Part B - General Practice, CCGs and the Francis Report

Organisational level – General practice

The Francis Inquiry looked at all organisations involved in turn to assess what was known by each organisation regarding concerns with the Trust and to what extent any action was taken to address their concerns. This includes local GPs, some of whom gave evidence to the original Inquiry.

When analysing the evidence from general practitioners, the inquiry found that local GPs only expressed substantive concern over care at the Trust following the news of the investigation. The inquiry goes on to say that this is not a direct criticism of GPs as they were not explicitly required to act in this way, although it does say that it is unfortunate that "it did not occur to any of them [GPs practicing in the local area] to report" the concerns they had at an earlier stage.

Responsibility for monitoring delivery of standards and quality

The report concludes that GPs have an important role in undertaking monitoring on behalf of their patients who receive acute hospital and other specialist services. It highlights that:

- GPs should have a role to check on the quality of service, in particular in relation to an assessment of outcomes.
- Internal systems are needed to enable GPs to flag any patterns of concern.
- GPs have a responsibility to their patients to keep themselves informed of the standards of local services and service providers to inform patient choice.
- GPs have an ongoing responsibility for their patients and that responsibility does not end on referral to hospital.
- GPs should take advantage of their position as commissioners to ensure patients get safe and effective care.

Commissioning

Focussing on lessons learnt, the report looks at the role of commissioners. It asserts that:

- Commissioners of services must ensure that those services are well provided and are provided safely.
- The minimum standards set by the CQC should not be the standard for contracting for services.
- Commissioners should aim to set standards over and above the minimum and should tackle non-compliance with these contracted standards.
- Commissioners should be the drivers for improvement in services.
- Resources are needed to adequately scrutinise the standard of services and CCGs should have the capacity to undertake audits, inspections and investigations, of individual and group cases.
- Commissioners should have powers of intervention where services are being provided which do not accord with their contracts.
- Commissioners should also consult others, as they deem necessary, including GPs and procurement expertise, to improve their commissioning arrangements.

Caring for patients: approaches applicable to all but in particular the elderly

When addressing continuity of care the report focuses on transition from hospital to the community and states that GPs and practices should, as a part of their professional obligations:

- Check on their patient after hospital treatment and assess whether the outcomes were satisfactory.
- Monitor patterns of concern which should be made known to the CQC and the relevant commissioner to keep themselves informed of the standard of service available from providers.

Effective Complaints Handling: Learning and information from complaints

The report recommends that commissioners should have as near to real-time access to complaints and information on their outcomes as possible. It suggests that CCGs should be required by the Commissioning Board to monitor this information and where appropriate to engage with complainants, either to support them in the pursuit of the complaint, or to assist in mediating a resolution.

Culture throughout the NHS

The report asserts that the NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. It suggests that 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 Department of Health, committed to and capable of involving all staff in putting into practice these 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.

Annex: RCGP Response to the Francis Report, 6th February 2013

The RCGP has responded to Sir Robert Francis QC's Public Inquiry report into Mid Staffs NHS Foundation Trust, published today (6/2/13).

RCGP Chair, Dr Clare Gerada said:

"What happened at Mid Staffordshire NHS Foundation Trust was system failure of the highest order and we are deeply saddened that so many patients and their families were let down, with such tragic results.

"Unfortunately, it demonstrates the extreme consequences of what can happen when the NHS loses sight of patient care on the ground in the scramble to balance budgets and achieve targets.

"Hospitals should be places where people feel safe and where they can trust the staff looking after them to deliver the care and kindness they deserve. They should not be institutions that strike fear and dread into the hearts of patients, in many cases even before they are admitted.

"While the Francis report focuses on failings in secondary care, it has implications for the whole of the NHS, including general practice. At a time when the NHS is under greater than ever financial pressure, it is imperative that the needs of patients are put first, and that cuts are not made which could jeopardise the safety of patient care.

"Two major changes must happen in the wake of the Francis report if we are to provide the necessary reassurance that the lessons of Mid Staffs have been learnt and, most importantly, that the same mistakes will not be repeated elsewhere in future.

"Firstly, we need to refocus and restore patient care back to its rightful place at the heart of everything we do, across the entire health service from the most junior healthcare assistant to the most senior consultant.

"Clinicians, including GPs and their teams, must be given the ability to do what is most important: listening to patients and caring for them.

"GPs have so far ridden the storm but financial constraints and top-down targets are starting to adversely affect the level of care we can deliver to our patients. We need to reverse this trend by increasing the number of GPs available to provide patient care, and by ensuring they are free to focus their attention on what matters most to patients.

"The second lesson we must take from the Francis report is the need to create an environment in which health professionals right across the NHS can raise concerns on behalf of their patients without fear of recrimination, and where concerns will be properly and thoroughly investigated. In anticipation of the report, the RCGP has produced a UK-wide position statement on raising concerns and whistle blowing in the NHS that we hope will prove invaluable for GPs, hospital staff and patients.

"The NHS was set up 65 years ago to provide fair and effective healthcare and to protect patients. If it is to continue doing this, the Government and all of us working in the NHS must stop underestimating the importance of kindness and compassion, the fundamentals of good patient care that cannot be budgeted for."