By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

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Subject: Francis Report: Overview

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1. Introduction

(a) Robert Francis QC was originally asked in July 2009 to chair an independent inquiry into care provided at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. This followed on from the publication of a report into the Trust by the Healthcare Commission in March 2009 and the reaction to its findings.

(b) The Department of Health and Trust Board accepted the recommendations of this first inquiry in full following publication in February 2010. Recommendation 16 was for Robert Francis to chair a non-statutory inquiry in public. A second non-statutory inquiry was commissioned. On 9 June 2010 the Secretary of State for Health announced this would be a public inquiry.

(c) The final report of this public inquiry was published on 6 February 2013. It is in 3 volumes along with an Executive Summary (c.1700 pages across volumes 1-3). The report contains 290 recommendations covering a wide range of areas.

(d) Given its length and the number of recommendations, together with the changes to the health sector underway as a result of the Health and Social Care Act 2012, the implications and impact of the Francis Report will take time to become clear. It is also important to see the findings of the report in their proper context. Robert Francis QC writes in the report: "What are perceived to be critical comments should not be taken out of context or in isolation from the rest of the report."[1]

2. Key Points

(a) Volume 1 of the report considers the warning signs about what was occurring at Mid-Staffordshire which existed during and prior to the relevant period. These included the loss of 'star ratings' which used to be issued by the Commission for Health Improvement, the findings of peer reviews, Healthcare Commission reviews and surveys, auditors reports, whistleblowing, a Royal College of Surgeon's report in January 2007, the Trust's financial recovery plan and evidence produced during the Trust's application for Foundation Trust (FT) status.

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[1] Volume 1, p.43.

(b) The report then goes on to consider what prevented concerns raised from being addressed and this covers volumes 1 and 2. The actions undertaken by a broad spectrum of organisations is considered and analysed. This list includes the Trust itself, other NHS organisations, the Department of Health, professional and sector regulators, local authority health scrutiny committees and patient groups like LINk and other local groups like CURE the NHS.

(c) From out of this a set of common themes as to why the problems were not discovered sooner are set out:[2]

- The Trust lacked insight into the reality of care being provided and was defensive in reaction to criticism.
- There were regulatory gaps in the responsibilities and accountabilities of external agencies.
- A lack of effective communication across the healthcare system.
- Loss of corporate memory from constant NHS reorganisation.
- A combination of the three above lead to a systemic culture where assurances given were not sufficiently challenged.
- This culture operated in a structure where identifying processes and meeting targets were how performance was measured.
- Finance and targets were prioritised over consideration of the quality of care.

(d) Volume 3 moves on to consider the culture and values in the NHS system before moving on to the recommendations and assorted appendices.

(e) The Executive Summary contains the following Conclusion:[3]

"The first inquiry report stated that it should be patients – not numbers – which counted. That remains the view of this Inquiry. The demands for financial control, corporate governance, commissioning and regulatory systems are understandable and in many cases necessary, but it is not the system itself which will ensure that the patient is put first day in and day out. It is the people working in the health service and those charged with developing healthcare policy that need to ensure that is the case.

"The extent of the failure of the system shown in this Inquiry's report suggests that a fundamental culture change is needed. That does not

[2] Adapted from Executive Summary, pp.64-5.
[3] Executive Summary, p.83

require a root and branch reorganisation – the system has had many of those – but it requires changes which can largely be implemented within the system that has now been created by the new reforms. I hope that the recommendations in this report can contribute to that end and put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it."

3. Next Steps

(a) A full Government response to the recommendations of the report is currently being prepared. The Prime Minister's statement on the issue on 6 February 2013[4] highlighted "three fundamental problems with the culture of our NHS." These are:

1. A focus on finance over patient care;

2. An attitude that patient care was always someone else's problem; and

3. Defensiveness and complacency.[5]

(b) The statement also included a number of things which had already been put into place and set out some actions which would be taken immediately. The Care Quality Commission has been asked to create a new post, that of 'chief inspector of hospitals.'

(c) Prior to this post being established, the NHS medical director, Professor Sir Bruce Keogh was asked "to conduct an immediate investigation into the care at hospitals with the highest mortality rates and to check that urgent remedial action is being taken."[6]

(d) There are a number of different ways to measure mortality rates in the NHS. Sir Bruce Keogh initially named five Trusts who had been outliers for a period of two years against the Summary Hospital-level Mortality Indicator (SHMI).[7] This was followed up by naming 9 Trusts who had been outliers for a period of two years against the Hospital Standardised Mortality Ratio (HSMR).[8] These Trusts are:

- Colchester Hospital University NHS Foundation Trust (SHMI)
- Tameside Hospital NHS Foundation Trust (SHMI)
- Blackpool Teaching Hospitals NHS Foundation Trust (SHMI)

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[4] House of Commons Hansard, *Mid Staffordshire NHS Foundation Trust (Inquiry)*, 6 February 2013, cols. 279-306.
[5] Ibid., Col. 280.
[6] Ibid., Col. 282.
[7] NHS Commissioning Board, *Professor Sir Bruce Keogh to investigate hospital outliers*, 6 February 2013, http://www.commissioningboard.nhs.uk/2013/02/06/sir-bruce-keogh/
[8] NHS Commissioning Board, *Sir Bruce Keogh announces final list of outliers*, 11 February 2013, http://www.commissioningboard.nhs.uk/2013/02/11/final-outliers/

- Basildon and Thurrock University Hospitals NHS Foundation Trust (SHMI)
- East Lancashire Hospitals NHS Trust (SHMI)
- North Cumbria University Hospitals NHS Trust (HSMR)
- United Lincolnshire Hospitals NHS Trust (HSMR)
- George Eliot Hospital NHS Trust (HSMR)
- Buckinghamshire Healthcare NHS Trust (HSMR)
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (HSMR)
- The Dudley Group NHS Foundation Trust (HSMR)
- Sherwood Forest Hospitals NHS Foundation Trust (HSMR)
- Medway NHS Foundation Trust (HSMR)
- Burton Hospitals NHS Foundation Trust (HSMR)

Background Documents

Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published 6 February 2013, http://www.midstaffspublicinquiry.com/report

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