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The Francis Report:A Wake-Up Call For The UK NHS

The final report of the public inquiry into care provided by the Mid Staffordshire NHS Foundation Trust has sent shockwaves across the NHS in the United Kingdom. The implications of this report, which received significant media attention, are likely to have a profound effect on the healthcare sector in the UK and serve as a warning for hospitals and healthcare systems around the world.

The Inquiry has been examining the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It has been considering why the serious problems at the Trust were not identified and acted on sooner, and identifying important lessons to be learnt for the future of patient care. It builds on Mr Francis's earlier report, published in 2010 after the earlier independent inquiry on the failings in the Mid Staffordshire NHS Foundation Trust between 2005 and 2009.

The Inquiry identifies a story of terrible and unnecessary suffering of hundreds of people who were failed by a system which ignored the warning signs of poor care and put corporate self interest and cost control ahead of patients and their safety. The findings and recommendations are relevant to hospitals across Europe and indeed the world. During these times of economic uncertainty and decreasing budgets hospitals must strive to put the patient at the centre of all activities.

Robert Francis QC, Chairman of the Inquiry made 290 recommendations designed to change this culture and make sure patients come first by creating a common patient centred culture across the NHS.

The Chairman's recommendations include:

A structure of fundamental standards and measures of compliance:

- A list of clear fundamental standards, which any patient is entitled to expect which identify the basic standards of care which should be in place to permit any hospital service to continue.
- These standards should be defined in genuine partnership with patients, the public and healthcare professionals and enshrined as duties, which healthcare providers must comply with.
- Non-compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service which exposes a patient to risk.
- To cause death or serious harm to a patient by non-compliance without reasonable excuse of the fundamental standards, should be a criminal offence.

Openness, transparency and candour throughout the system underpinned by statute. Without this a common culture of being open and honest with patients and regulators will not spread. Including:

- A statutory duty to be truthful to patients where harm has or may have been caused.
- Staff to be obliged by statute to make their employers aware of incidents in which harm has been or may have been caused to a patient.
- Trusts have to be open and honest in their quality accounts describing their faults as well as their successes.
- The deliberate obstruction of the performance of these duties and the deliberate deception of patients and the public should be a criminal offence.
- It should be a criminal offence for the directors of Trusts to give deliberately misleading information to the public and the regulators.

Improved support for compassionate, caring and committed nursing

- Entrants to the nursing profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of patients.
- Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard.
- Nurses need a stronger voice, including representation in organisational leadership and the encouragement of nursing leadership at ward level.
- Healthcare workers should be regulated by a registration scheme, preventing those who should not be entrusted with the care of patients from being employed to do so.

Stronger healthcare leadership

- The establishment of an NHS leadership college, offering all potential and current leaders the chance to share in a common form of

training to exemplify and implement a common culture, code of ethics and conduct.

- It should be possible to disqualify those guilty of serious breaches of the code of conduct or otherwise found unfit from eligibility for leadership posts.
- A registration scheme and a requirement need to be established that only fit and proper persons are eligible to be directors of NHS organisations.

Government Apology

Prime Minister, David Cameron spoke out on the issue stating, “What happened at The Mid-Staffordshire NHS Foundation Trust between 2005 and 2009 was not just wrong, it was truly dreadful.” Addressing the House of Commons, Cameron also saw fit to apologise to the patients and families concerned. “On behalf of the government – and indeed our country – I am truly sorry.” He apologised for the system that “allowed this horrific abuse to go unchecked and unchallenged for so long.”

Talking about the report, Francis emphasised the importance of enforcing standards by law, “Senior managers should be made accountable, patients need to be protected from poor nursing standards and all staff should be empowered to be open and transparent when it comes to the well- being of the people in the care.”

Conscious of shock and scandal surrounding the findings of both the independent and public inquiries, Francis was keen to highlight a positive path for the future, “The recommendations I am making today represent not the end but the beginning of a journey towards a healthier culture in the NHS where patients are the first and foremost consideration of the system and all those who work in it. It is the individual duty of every organisation and individual within the service to read this report and begin working on its recommendations today.”

The report can be read in full at **www.midstaffspublicinquiry.com**

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