Recommendations of the Francis Report into the Mid-Staffordshire Hospitals NHS Foundation Trust

House of Lords debate, Monday 11th March 2013

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors from all branches of medicine across the UK. It has a total membership of over 152,000.

Introduction
The BMA was profoundly disturbed and saddened by the failures at Mid Staffordshire NHS Trust, which resulted in tragedy for so many patients and their families. The thorough and measured report by Robert Francis QC into events at the Trust demonstrates a clear need for politicians, NHS organisations, doctors, managers, nurses and patient groups to work together to create a different kind of health service which demonstrates zero tolerance of poor and dangerous care.

The BMA will do all it can to work with others in developing a new culture in the NHS to prevent similar catastrophes from happening again. There must be an urgent shift towards more openness, transparency and candour throughout the NHS that values learning from mistakes and which puts the patient at the centre of the health service. Doctors, along with other clinical staff, have a professional responsibility to show leadership in helping to change this culture. Improved training, information sharing and support for healthcare professionals are vital in making change happen.

A shift in culture is needed to end the climate of fear, bullying and harassment that can stop clinicians from speaking out against poor care. It is essential that medical staff and management jointly promote the ethos that raising concerns is not only acceptable but positive. However, the BMA does not believe that pursuing the recommendation in the Report to move to a statutory duty of candour is the right way forward. There are already clear professional duties on doctors to raise and act on concerns about patient safety. A further ‘blunt’ instrument of legislation could create the wrong sort of culture change, encouraging defensive practice rather than a professional commitment to openness and partnership.

The BMA is committed to making the most of the opportunities presented by the recommendations in the Report to ensure that the NHS is providing the best possible quality of care for all of its patients. We will need to reflect on and consider the 290 recommendations in the Report, and in particular those that deal with NHS culture, medical training, regulation, data and information very carefully. We will respond in detail to specific recommendations in due course.

NHS culture
The Report highlights the culture of the NHS as a major cause of many of the failings at Mid Staffordshire. An environment lacking in openness, transparency and candour meant that there was a fear of raising concerns, a learned tolerance of poor patient care and a failure to put patients first. The Report also rightly criticises the drive towards achieving top-down targets and the effects of constant NHS reorganisation, which meant that even the most basic clinical care was sidelined in the race to meet deadlines.

We believe that openness, transparency and candour must be ensured throughout the system about matters of concern. A common culture, shared by all, in the service of putting the patient first, needs to be truly realised. A number of recommendations are made in the Report about
making greater use of the NHS Constitution, as one of the avenues to help foster a shift in culture. The BMA believes that this is an important lever and we will continue to play an active role in contributing towards discussion on how the NHS Constitution can be further developed.

We also believe that openness, transparency and candour must equally extend to reforms and reorganisations in the NHS. The BMA accepts that it will sometimes be necessary to review and change the way services are delivered and that this may in some circumstances involve cuts, including to staffing levels. However, reforms need to be introduced in a considered way, in consultation with clinicians and other health professionals, and in a way which does not at any stage jeopardise patient safety. This must always come first.

The BMA is concerned that these principles are not being adhered to in current reconfigurations in the NHS. For example, a review of mental health services by Norfolk and Suffolk NHS Foundation Trust, which proposes cuts to both staffing and bed numbers, has seen some of the changes being implemented prior to the completion of the consultation. This is totally unacceptable and demonstrates a lack of commitment to genuine consultation with staff, stakeholders, service users and carers, and could put patient safety at risk.

**Raising concerns**
The Report rightly raises the responsibility upon individuals and organisations to raise concerns about patient safety and poor standards of care. There are already very clear professional duties on doctors, outlined in the General Medical Council’s guidance, *Good Medical Practice*, to be open and honest with patients if things go wrong and to raise and act on concerns about patient safety. The BMA believes that we can and must do more to promote and monitor these duties, whilst also removing any barriers to doctors fulfilling these obligations. The BMA welcomes the Report’s findings that NHS organisations must do more to listen and act on the concerns of staff. Placing a corresponding duty on healthcare providers ‘to listen’ could send a positive and reassuring sign to staff that they will be heard without fear of punitive action.

However, the Report states that existing obligations on individuals to report concerns do not go far enough in enforcing the need for staff to disclose important information. The Report makes two key recommendations: a statutory obligation to observe a duty of candour; the introduction of criminal sanctions against those obstructing the duty of candour.

The BMA is concerned that moves to a statutory duty of candour may create a negative culture of fear, encouraging defensive practice rather than a professional commitment to openness and partnership. The practical difficulties in enforcing a statutory duty of candour must also be considered. Rather, there is a need to address the underlying culture in the NHS, which can prevent doctors reporting concerns, and to look at alternative ways of ensuring that doctors feel able to report their fears, such as a separate reporting route parallel to management.

**Leadership**
The Report makes several recommendations for improving leadership in the NHS after the discovery of failings at every level at the Trust. The BMA has taken on board comments in the Report that senior clinical staff were disengaged from managerial and leadership responsibilities. The BMA believes that doctors, along with other clinical staff, have a professional responsibility to show leadership in helping to change culture within the NHS. Improved training, information sharing and support for healthcare professionals are also vital in making change happen.

**Professional values and practice**
The Report recommends the development and introduction of fundamental standards of patient safety and patient care as a means of tackling the lack of focus on standards of service, and professional disengagement by healthcare professionals about the poor levels of care being delivered at Mid Staffordshire. The BMA is looking at this recommendation in more detail.
**Education and training**

The Report makes a number of recommendations on the education and training of all the key contributors to the provision of healthcare – several of these are of direct relevance to medical education and training, which we are closely considering.

For example, the Report refers to trainees as the ‘valuable eyes and ears’ in a hospital setting. It recommends that medical students are asked by their placement providers for feedback on an organisation’s compliance with patient safety standards. We strongly believe that there should be support systems in place to enable junior staff and medical students to speak up when they have concerns about patient safety.

The Report also highlighted how the checks and assurances of the education and training system failed to detect any concerns about Mid Staffordshire and possible warning signs were given insufficient attention. A key recommendation includes the need for training regulators to be informed of any concerns uncovered by any review that may have implications for the acceptability of training at that organisation.

The Report recommends that postgraduate deaneries, commissioners, the General Medical Council and regulators should review information shared between them about patient safety.

**Information**

The Report makes almost 30 recommendations about how information can be used to transform the NHS, noting that accurate, useful and relevant information is vital to an open, transparent and candid culture in the health service. There are specific roles for doctors, as the Report states that all professionals, individually and collectively, should be obliged to take part in the development, use and publication of more sophisticated measurements of the effectiveness of what they do, and of their compliance with fundamental standards.

The BMA agrees that a more open and transparent approach is needed in the NHS that values learning from mistakes and which puts the patient experience at its centre. We believe that good systems and data are needed to enable clinical teams to identify and rectify problems as early and quickly as possible – we are considering the detailed recommendations.

**The role of the BMA**

The BMA acknowledges comments within the Report regarding the role of trade unions at Mid Staffordshire, either in seeking to protect patients or driving up standards at the Trust. The Report also found that concerns were not raised about the quality of care provided at Mid Staffordshire by local GPs, recommending improved scrutiny by commissioning groups and local GPs, with good support mechanisms in place to allow them to do this. The Report notes that the new commissioning process will be crucial, with GPs undertaking a monitoring role on behalf of patients who receive acute hospital and other specialist services.

In light of the Report, the BMA is committed to reviewing its processes for supporting and protecting individual members, whilst upholding standards of patient safety and good medical practice. GP leaders at the BMA are studying the Report to ensure that patients always have the best experience possible from the NHS, and will work with the Government on interpreting the Report’s recommendations on this issue.
References

1 Chapter 22, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 3
2 Recommendation 181, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 3
3 Recommendation 183, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 3
5 Chapter 21, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 3
6 Chapter 26, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 3
7 The BMA has recently added a new section on our website which provides doctors with resources to support them if they need to raise concerns, develop their clinical leadership skills or to find out more about quality and regulation: www.bma.org.uk/midstaffordshireinquiry