Robert Francis: Lessons from Stafford

I am sometimes asked why I think my recommendations are going to work when a significant number of things that I have said was said so many years ago by Sir Ian Kennedy and no doubt by other people in other reports. And one can perhaps make the question even more severe by going even further back than that to what Florence Nightingale had to say in 1863 about it being a strange principle. But I have to say that the very first requirement of a hospital is that it should do the sick no harm. A few figures there, over a million pages of documentary material were digested by my enquiry team. We have statements from well over 250 witnesses. We had 139 days of oral hearing. Much comment has been made about the fact that the report is said not to single out individuals and in one particular sense hold them to account. However, I would suggest that those of you who read the report and perhaps most importantly those who haven't, should reflect on the fact that the report contains on a chapter-by-chapter basis, explanations and descriptions of what individuals did, what they didn't do and what that was going through the minds at the time.

Now, can I move on to Stafford, but we tend to forget that most healthcare in this country is delivered in places like Stafford which are bypassed by motorways taking people going to where they think are important places; which are lived in by what we charmingly call "ordinary people" who is what the service is there for. This is an extract from a report about a serious incident in which a lady had died 11 days after she had been admitted to a hospital with a broken leg. She was recorded on her admission to hospital as being an insulin-dependent diabetic. Eleven days later, she died because she had not been given insulin. And the investigation conducted conscientiously concluded, with that list of failures, a conclusion that there was several systemic failures issues which caused this to occur. Unfortunately, it cannot be said these were isolated and it was clear that similar issues were occurring regularly.

The report was not seen by the board because it was thought this sort of matter was operational not strategic and one does feel as was looking at that report alone, you would know something very seriously was wrong. This wasn't just a one-off mistake. Now, lots of people didn't actually complain and why didn't they? Well, these are just some of the reasons that cropped up in the course of evidence which I'm sure many of you here would find quite typical throughout the health service. There is the fear of the consequence from the reaction from nurses, or whoever, if you complain. There is a feeling of fear. There is being told not to moan and finally that most British of all the reactions, “I don't want to be a nuisance”. But complaints were made and this comes out of the first report. And, depressingly, there was a pattern and there also tended to be a pattern, there would be a complaint, there would be a response which contained an apology, an action plan not put into force. The same thing happens again, the same apology is issued and pretty well the same action plan and people carry on not being cared for properly.

The reaction of staff is important. Staff get a very bad press and it's only right to recognise the stresses and strains of working in a place where poor care is being provided. And this nurse felt ashamed when she was working there and that she went home and she is upset because you can't say you've done anything to help. There weren't enough staff to deal with the patients who needed to deal with, provide everything the patient would need. You were doing, you were just skimming the surface and that wasn't how I was trained.

Now, people shouldn't be required to work in such conditions. But there is of course the other side to the professions which they need to reflect on. This was from the transcripts the evidence given to the second enquiry by a senior soon-to-retire consultant. And he is saying, he didn't have a managerial role, he didn't see, therefore, himself as someone who had to get involved. Perhaps my conscience may have maybe raised concerns but I took the path of least resistance. Most of my patients were day cases and there was less impact. There were also veiled threats at the time that I shouldn't rock the boat at my stage in life because, for example, I need a discretionary point. And a very candid approach, but probably more take that approach than would ever care to admit it in public. It is tempting, isn't it, faced with a disaster like this to do what has often happened before which is to enhance a whole-scale reorganisation, abolish this organisation, set up someone else and do that around. But we know that it doesn't, in itself, work.

What I have tried to do, what I was actually asked to do was to apply the lessons to be learned to the system as it now is. Firstly, values. These are my suggestions the values but obviously, there may be others. There are values all over the NHS, and they're even in the NHS constitution but most of them are stuck in an appendix rather than upfront. And it should be - the first simple point, you have got to put patients first. Fundamental standards, I will say a few words about these. I think the standards that we now have are too remote in real life from the people at the frontline. These are examples of the sort of thing, I would hope, we would all think if we work - we aren't doing it or actually it'd be unacceptable. Medication that is prescribed should be given, if it isn't, it's unacceptable. Water and food to sustain life and help required to give it must be given. Cleanliness of patients and equipment, you've got to have assistance to go to the lavatory if you need it and you need consent for treatment where that is necessary.

Openness, transparency and candour; and so I do say there should be a statutory obligation on the organisation, this is the point, to tell the patient that harm has been done and there needs to be a statutory obligation on individuals to tell the organisation about those incidents. Can we please ban gagging clauses? Can we please welcome concerns and complaints? Can we get real feedback and actually do something about it and can the trust board please consider that feedback? And can we please share information on actual cases, the sort of stories I'd put up on the screen with commissioners, regulators and the public? And above all, can we make sure something is done about the concerns that are raised?

Nursing. You will know I recommended that we should have a registration requirement for health care support workers. Isn't it odd that the security guard at the door of the hospital have more regulation attached to them and more sanction available to their supervision than does the support worker who is cleaning the bottom of your grandmother? And I just don't think that is acceptable anymore. Leadership is everything and it's at every level. If we're going to have common values and we're going to have leaders who exemplify and spread them, I think we need more of a corp d'esprit, if you like, which could develop through a physical staff college, rather than the many commendable, rather more virtuous schemes we've had over the last few years which have a habit, I'm afraid, of fading away, however good they are. We need voluntary accreditation, we need to encourage people to get things and qualifications which make them better leaders and I don't think that's too much to ask. But we do need accountability, there's a big cry for accountability and that's perfectly

understandable. And where there is a serious default on the part of leaders of trust there should be consequences.

Finally, but by no means least, information, we need information that enables you and I when we're going to a hospital, to know what the performance is like of the surgeon who might be operating on it. That won't always be relevant but we need to know what the infection rates are in Ward 11 as opposed to Ward 10 in a way which makes sense to us. To do that, the professionals have got to step up to the plate and devise methods to enable us to make that comparison. The final thought; culture change does not have to wait for the government to tell you what to do, everyone can start to do something about this themselves. Thank you very much.