



The Francis Report (Report of the Mid-Staffordshire NHS Foundation Trust public inquiry) and the Government's response

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On 6 February 2013 the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC, was published. This public inquiry followed a number of earlier inquiries and was specifically established to examine why serious failures in care at Mid-Staffordshire NHS Foundation Trust before 2009 were not acted on sooner by the various responsible organisations.

The Francis Report made 290 recommendations designed to create “a common patient centred culture across the NHS”. Key themes included the need for clear fundamental standards and measures of compliance, and greater openness, transparency and candour throughout the system, underpinned by statute where necessary.

This briefing provides background to the public inquiry led by Robert Francis QC, and other preceding reviews. It also provides some information on the Government's initial response to the Francis report, which was published on 6 February 2013. The Government detailed response to each of the 290 recommendations, *Hard Truths, the Journey to Putting Patients First*, was published on 19 November 2013. The Government fully or partially accepts all but nine of the Francis recommendations.

Some of the measures set out in Part 2 of the Care Bill are in response to specific recommendations about transparency and the regulation of care standards in the Francis Report and further information about these can be found in the Library Standard Note, *Lords stages of the Care Bill: Health provisions* (SN06769).

Two further Library standard notes refer to the public inquiry, and specific policies announced in response to the earlier inquiries, *NHS whistleblowing procedures in England* (SN06490) and *NHS complaints procedures in England* (SN05401).

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1 Initial reports into care at Stafford Hospital and the First Francis inquiry

In 2008 the then healthcare regulator, the Healthcare Commission, launched a review into standards of care at Stafford Hospital, part of the Mid-Staffordshire NHS Foundation Trust, prompted by concerns about the Trust's high hospital standardised mortality ratio, and in response to complaints from patients and their relatives.

In March 2009 the Healthcare Commission published its report, which revealed serious failures in care over the period from 2005 to 2008. As well as immediate steps to try and improve patient safety, care standards and public confidence, including the appointment of a new chair and chief executive in July 2009 and a programme of regular inspections by the Care Quality Commission, the Government set up a review led by Dr Colin Thomé¹ and an independent inquiry led by Robert Francis QC.² These reports found widespread and systemic deficiencies in care at the Trust, including a lack of effective governance arrangements. The Foundation Trust and the key professional regulatory bodies, the General Medical Council and the Nursing and Midwifery Council, have also investigated a number of clinical staff potentially implicated by events at Stafford Hospital.³

1.1 The first Francis inquiry and the previous Government's response

In July 2009 the Secretary of State for Health under the previous Government, Andy Burnham, commissioned Robert Francis QC to conduct an independent inquiry in to what went wrong at Stafford hospital and why; what lessons could be learned; and what further action was needed to ensure the trust was delivering a sustainably good service to its local population.

The inquiry found evidence of an organisation with a culture "not conducive to providing good care for patients or a supportive working environment for staff". The board did not consider patient complaints, clinical governance or quality at its meetings. Meetings were held in private, and the report describes the board as having "lost sight of its fundamental responsibility to provide safe care." That dysfunctionality extended to the way targets were

¹ *Mid Staffordshire NHS Foundation Trust: A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation*, (Dr David Colin Thomé), 29 April 2009

² *The Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust*, (chaired by Robert Francis QC), 24 February 2010

³ <http://www.telegraph.co.uk/health/healthnews/8131135/Nurses-and-doctors-face-being-struck-off-over-Stafford-Hospital-scandal.html>

managed in the trust and the failure to put in place adequate staffing levels to provide safe patient care. The management of the trust cut staffing to dangerously low levels, at one point leaving A and E with a third fewer nurses than were needed to provide safe care. Among staff the report found failures of professional standards and clinical leadership.

In total, Robert Francis made 18 recommendations, most relating to the Trust with some applying the NHS more generally, or to the Department of Health. Recommendations included that the Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard. The report recommended that the NHS and Department review arrangements for the training, appointment, support and accountability of executive and non-executive directors of NHS trusts and NHS foundation trusts. It also recommended that the Department should set up a working group to review the use of comparative hospital mortality statistics:

In view of the uncertainties surrounding the use of comparative mortality statistics in assessing hospital performance and the understanding of the term 'excess' deaths, an independent working group should be set up by the Department of Health to examine and report on the methodologies in use. It should make recommendations as to how such mortality statistics should be collected, analysed and published, both to promote public confidence and understanding of the process, and to assist hospitals to use such statistics as a prompt to examine particular areas of patient care.

Finally the first Francis report recommended that the Government should "consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified."

In his response to the Francis Inquiry in February 2010 Andy Burnham said the Government accepted all the recommendations in full. Turning to the four recommendations that applied to his Department, the Health Secretary announced he would consult on a new system of professional accreditation for senior NHS managers; improve early warning systems in the NHS; update "whistleblowing" guidance; and place a greater focus in the NHS on measuring patient satisfaction and staff satisfaction. Some key sections of his response are set out in full:

... Robert Francis asks me to review how comparative mortality statistics are compiled, as well as the methodologies that underpin them, to improve public confidence in and understanding of them. One of the principal reasons why the Healthcare Commission launched its review in 2008 was that it was not satisfied with the trust's explanation of its high hospital standardised mortality ratio. The inquiry has consulted a range of experts on the issue, and Robert Francis concludes:

"it is in my view misleading and a potential misuse of the figures to extrapolate from them a conclusion that any particular number or range of numbers of deaths were caused or contributed to by inadequate care".

However, as he points out, there is no shared methodology for HSMRs, nor any clear account of how they should be used and interpreted. The result is confusion for patients and the public. I therefore welcome and accept the recommendation to establish an independent working group to examine and report on the methodologies in use. The NHS medical director, Professor Sir Bruce Keogh, has already established that group, which includes the key parties involved in developing and using HSMRs, as

well as leading academics and others. The group has committed to developing a single HSMR for the NHS.

... the report calls for a further independent examination of all the commissioning, supervisory and regulatory bodies, in relation to their monitoring role at Stafford, with the objective of learning lessons about how failing hospitals are identified. I accept that recommendation, and can tell the House that Robert Francis has agreed to chair the further inquiry. We are publishing draft terms of reference today, and we welcome views on them.⁴

2 The Public Inquiry and the current Government's response

2.1 Background

On 9 June 2010 the new Secretary of State for Health, Andrew Lansley, announced that Robert Francis had agreed to chair a second inquiry, which unlike the first would be held in public. In addition to being held in public, this inquiry had statutory powers to compel witnesses to attend and speak under oath under the *Inquiries Act 2005*. It was expected that Robert Francis would submit his report to the Secretary of State on 15 October 2012 but this was pushed back to 5 February 2013, with publication to take place the following day.⁵

Unlike the previous inquiries, which focussed on failings within the Trust, the public inquiry looked at the operation of the commissioning, supervisory and regulatory bodies responsible for the Trust. In his statement to the House, the Secretary of State explained the rationale for the new inquiry:

This was a failure of the trust first and foremost, but it was also a national failure of the regulatory and supervisory system, which should have secured the quality and safety of patient care. (...)

Why did the primary care trust and strategic health authority not see what was happening and intervene earlier? How was the trust able to gain foundation status while clinical standards were so poor? Why did the regulatory bodies not act sooner to investigate a trust whose mortality rates had been significantly higher than the average since 2003 and whose record in dealing with serious complaints was so poor? The public deserve answers.⁶

The Shadow Secretary of State, Andy Burnham, gave an assurance that the new inquiry would have the Opposition's full co-operation. He also highlighted that he had signalled the need for a "second stage inquiry" before the General Election, to look into the actions of the supervisory and regulatory bodies.⁷

2.2 Report of the Public Inquiry

The *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, was published on 6 February 2013 and included 290 recommendations.⁸ This was accompanied by a statement to the House by the Prime Minister which set out actions already taken and a commitment that the Government would "respond in detail next month".⁹ The Government

⁴ Statement by the Secretary of State for Health, Andy Burnham, [HC Deb 24 February 2010 c310-11](#)

⁵ Further information about the public inquiry is available here: <http://www.midstaffspublicinquiry.com/>

⁶ [HC Deb 9 June 2010, c333](#)

⁷ *Ibid.* c335

⁸ Further information about the public inquiry is available here: <http://www.midstaffspublicinquiry.com/>

⁹ [HC Deb 6 February 2013 c281](#)

published more detail in its initial published response, *Patients First and Foremost*, on 26 March 2013.¹⁰

A press release issued by the public inquiry noted that the inquiry had found “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 final report 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”.¹¹

The press release highlighted some of the report’s key recommendations:

- **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.
 - Standard procedures and guidance to enable organisation and individuals to comply with these fundamental standards should be produced by the National Institute for Clinical Excellence with the help of professional and patient organisations.
 - These fundamental standards should be policed by the Care Quality Commission (CQC)

- **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

¹⁰ [Patients First and Foremost: the Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#) (26 March 2013).

¹¹ The Mid Staffordshire NHS Foundation Trust Public Inquiry, *Publication of the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, press release, 6 February 2013, p1

- 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
- The CQC should be responsible for policing these obligations
- **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.¹²

Commenting on his recommendations Robert Francis said:

The NHS can provide great care and the system and the people in it should make sure that happens everywhere. 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.”¹³

The website for the public inquiry is available at:

<http://www.midstaffspublicinquiry.com/home>

The final report and associated documents can be found at:

<http://www.midstaffspublicinquiry.com/report>

¹² As above, pp1–3

¹³ As above, p3

2.3 The Prime Minister's response

Following the publication of the report, the Prime Minister made a statement to the House, which highlighted how the different layers of NHS management had failed to address the failings at Mid-Staffs NHS Foundation Trust:

The inquiry finds that the appalling suffering at the Mid Staffordshire hospital was primarily caused by a “serious failure” on the part of the trust board, which failed to listen to patients and staff and failed to tackle what Robert Francis calls

“an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.”

The inquiry finds, however, that the failure went far wider. The primary care trust assumed others were taking responsibility and so made little attempt to collect proper information on the quality of care. The strategic health authority was “far too remote from the patients it was there to serve, and it failed to be sufficiently sensitive to signs that patients might be at risk.”

Regulators, including Monitor and the then Healthcare Commission, failed to protect patients from substandard care. Too many doctors “kept their heads down” instead of speaking out when things were wrong. The Royal College of Nursing was “ineffective both as a professional representative organisation and as a trade union” and the Department of Health was too remote from the reality of the services that it oversees.¹⁴

The Prime Minister cautioned that “the way Robert Francis chronicles the evidence of systemic failure means that we cannot say with confidence that failings of care are limited to one hospital”.¹⁵

The Prime Minister apologised for the failing at the Foundation Trust, and noted that action had been, including the establishment of a National Quality Board and the quality accounts system under the previous Government, and that his Government have:

- “...put compassion ahead of process-driven bureaucratic targets”
- “...put quality of care on a par with quality of treatment” and “set this out explicitly in the mandate to the NHS Commissioning Board, together with a new vision for compassionate nursing”;
- “...introduced a tough new programme for tracking and eliminating falls, pressure sores and hospital infections”; and
- “...demanded nursing rounds, every hour, in every ward of every hospital”.¹⁶

He concluded, however, that “it is clear that we need to do more”, and said that the Government “will study every one of the 290 recommendations in today’s report and ... respond in detail next month”.¹⁷ He added that “immediate progress” was needed in “three core areas—patient care, accountability and defeating complacency”:

Patient Care

¹⁴ [HC Deb 6 February 2013 cc279–280](#)

¹⁵ [HC Deb 6 February 2013 c280](#)

¹⁶ [HC Deb 6 February 2013 cc280–281](#)

¹⁷ [HC Deb 6 February 2013 c281](#)

- Explaining how patient care would be put ahead of finances, the Prime Minister noted that “today, when a hospital fails financially, its chair can be dismissed and the board can be suspended, but failures in care rarely carry such consequences”. He continued “that is not right, so we will create a single failure regime, where the suspension of the board can be triggered by failures in care as well as failures in finance, and we will put the voice of patients and staff at the heart of the way in which hospitals go about their work”. This would mean that “where a significant proportion of patients or staff raise serious concerns about what is happening in a hospital, immediate inspection will result and suspension of the hospital board may well follow”.
- The Prime Minister confirmed plans to introduce a “friends and family test” for NHS services, and said that from this year every patient, carer and member of staff would be given the opportunity to say whether they would recommend their hospital. He said that survey results would be published and that “where a significant proportion of patients or staff raise serious concerns... immediate inspection will result and suspension of the hospital board may well follow”.
- He said he had asked Don Berwick, previously a health policy advisor to the President of the United States, to embed the concept of “zero harm” within the NHS.¹⁸
- Addressing some of the report’s recommendations on nursing and healthcare assistants the Prime Minister said that nurses should be hired and promoted on the basis of having compassion as a vocation, not just academic qualifications.

Accountability and transparency

- On accountability and transparency, the Prime Minister noted that “the first Francis report set out very clearly what happened within Stafford hospital, and it should have led to those responsible being brought to book by the board, by the regulators, by the professional bodies and by the courts. But that did not happen”, adding that “the system failed”.
- He said “the Nursing and Midwifery Council and the General Medical Council need to explain why, so far, no one has been struck off”, and noted that they had been invited by the Secretary of State for Health “to explain what steps they will take to strengthen their systems of accountability in the light of this report”.
- He said the Government would “ask the Law Commission to advise on sweeping away the Nursing and Midwifery Council’s outdated and inflexible decision-making processes”.
- He said that “the Health and Safety Executive also needs to explain its decisions not to prosecute in specific cases”, adding that the Government would “look closely at his recommendation to transfer the right to conduct criminal prosecutions away from the HSE to the Care Quality Commission”.

Culture of complacency

¹⁸ [HC Deb 6 February 2013 c281](#)

- the Prime Minister said “we must purge the culture of complacency that is undermining the quality of care in our country”, adding “we need a hospital inspections regime that does not just look at numerical targets but examines the quality of care and makes an open, public and explicit judgment”.
- The Prime Minister said he had asked the Care Quality Commission to create a new post, a “chief inspector of hospitals” in order to “take personal responsibility for that task” with the new regime beginning in autumn 2013.
- In the meantime, the Prime Minister said he had “asked the NHS medical director, Professor Sir Bruce Keogh, 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”.
- In addition, he had asked Ann Clwyd MP and the chief executive of South Tees Hospitals NHS Foundation Trust, Tricia Hart, “to advise on how NHS hospitals can handle complaints better in the future”.¹⁹

2.4 Patients First and Foremost

Detail on the Government’s response can be found in [Patients First and Foremost: the Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#) (26 March 2013). This set out a five point plan to improve the care that people receive from the NHS:

Preventing and detecting problems

The sections on preventing and detecting problems provided further information on proposals for a Chief Inspector of Hospitals and it was subsequently announced that Professor Sir Mike Richards had been appointed to this post. He will lead a national team of hospital inspectors that will carry out targeted inspections in response to quality concerns and regional teams of inspectors who will undertake routine inspections on a regular basis of all hospitals. He will also lead the development of a ratings system for NHS acute hospitals and mental health trusts. It also noted plans to publish information on surgical outcomes, to introduce penalties for disinformation, a statutory duty of candour and a ban on contractual clauses that seek to prevent NHS staff whistleblowing.

Taking action promptly

This section included further detail of plans for a failure regime, in which a Trust or Foundation Trust Board could be suspended and the hospital put into administration if it fails to meet fundamental standards of care.

Ensuring robust accountability

This section stated that as part of the Law Commission’s review of the legislation that applies to the professional regulators, the Government would seek to legislate at the earliest opportunity to consolidate measures into a single Act that would enable “faster and more proactive action on individual professional failings”. This section also outlined proposals for a barring scheme for “failed NHS managers”.

Ensuring staff are trained and motivated

This section set out plans for student nurses to serve up to a year as a healthcare assistant first, “to promote frontline caring experience and values”, and to introduce a revalidation

¹⁹ [HC Deb 6 February 2013 cc281–283](#)

scheme for nurses. It also set out proposals for minimum training standards and a barring scheme for healthcare assistants.