MIXED REVIEWS FOR

It was one of the most eagerly – and nervously – anticipated reports in the history of the NHS. Yet the feeling among experts gathered to discuss Robert Francis's weighty tome was one of anti-climax, reports Alison Moore

The Francis report may be remembered as a symbol of a changing NHS rather than for its detailed recommendations, many of which are incoherent, over-complicated and even simply unnecessary.

That was the message from a panel of experts at an *HSJ* roundtable to discuss the report last Friday, sponsored by healthcare law firm Capsticks.

King's Fund senior fellow Nigel Edwards spoke for many around the table when he said that in 10 years' time people would say they were doing better in care of elderly people and that the Francis report was a staging point on the way – but it might not radically alter the direction of policy.

And he quoted professor of health policy Kieran Walshe who had suggested that public inquiries had influence on policy in inverse proportion to the number of recommendations they contained. The Francis report has 290.

HSJ editor Alastair McLellan said he thought it was the most important of the 30 to 40 roundtables he had chaired over the last three years and urged participants to cut through the murk surrounding Francis: "The question we have to answer is what is going to change and why."

What did the panel think were the most important and most desirable recommendations coming out of Francis? Harry Cayton, chief executive of the Professional Standards Authority for Health and Social Care, said it was the recommendation on patient-centred care.

"But, although I think it is the most important recommendation, I think it is the least likely ever to be implemented," he said. And he revealed that he had recently heard the health secretary speaking at a medical charity reception and refer to elderly people who were repeatedly admitted to hospital as "frequent flyers". "He has picked up that language from the senior NHS people... to me that shows that there is no cultural change at all at the top of the system," he said.

'Public inquiries influence policy in inverse proportion to their number of recommendations. The Francis report has 290'

And he said the report's recommendations around implementing a patient-centred focus were "fairly woolly". "Relying on the NHS Constitution? The vast majority don't even know it exists," he said.

"The rights in it are only basic human rights and everything else is a pledge. A pledge to me is just a form of polish."

Neil Hunt, chief executive of the Royal College of General Practitioners, said the proposals for elderly care were significant. "The system is not engaging with the changing patient population," he said. "There's an ageism in the system." The section on continuing care and responsibility for it was also important.

Importance of values

General Medical Council chief executive Niall Dickson was more optimistic, highlighting recommendations two and four – on values and patient-centred care – as talking about the right things. "Quality is not the organising principle of the NHS at the moment," he said. "There is a lot of emphasis on regulation being the answer. But I think a lot of the answer lies with the boards of institutions and organisations and with professionals working within organisations." How professional and organisational goals were aligned was also important, he added.

Capsticks partner Gerard Hanratty said getting clarity from the Care Quality Commission was important for the NHS: sometimes it was hard to divine what was needed from organisations to satisfy it, he said.

Mr Edwards – who was one of the expert reviewers called in during the final stages of the report's preparation – said: "If you look at the history of reports there is symbolic importance rather than the details... it's what they stand for rather than the long list of recommendations.

"It is a reference point for what is going wrong and should not happen again rather than being anything specific that you seize on and say that it is a real game changer."

Many things highlighted in the report should be happening anyway, he said. There were positive areas such as care of the elderly, information being shared with patients, and GPs following up patients after discharge.

"The rest of it is somewhat nebulous. The moment you mention culture change or changing undergraduate education then you know the argument is intellectually exhausted."

And he pointed out many of the mechanisms to change behaviour and culture were not available through a report such as this.

Jeremy Taylor, chief executive of National Voices, said the report was deeply flawed and did not do justice to the public voice. "The good stuff tends to be very woolly and motherhood and apple pie... the more specific he is, the less happy I am."

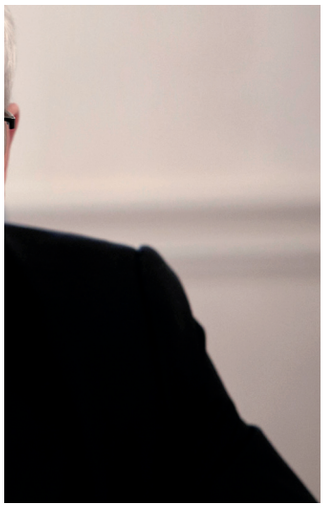
But he said he was pleased the statutory duty of candour had been included. "Everyone knows that a change in the law does not necessarily change practice but it is a good example of a really symbolic change."

Former Circle chief executive Ali Parsa welcomed the recommendations around transparency but warned this was not something that would

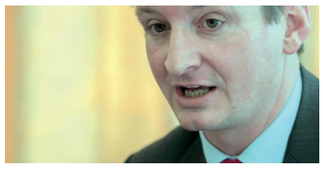
ROUNDTABLE PARTICIPANTS

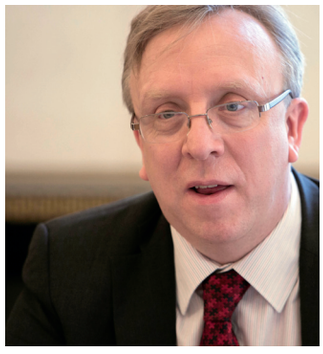
Alastair McLellan *HSJ* editor and roundtable chair
Peter Carter chief executive, Royal College of Nursing
Harry Cayton chief executive, Professional Standards Authority for Health and Social Care
Niall Dickson chief executive and registrar, General Medical Council
Nigel Edwards senior fellow, The King's Fund and director, global healthcare group, KPMG
Gerard Hanratty partner, Capsticks
Ruth Holt director of nursing, NHS Confederation
Neil Hunt chief executive, Royal College of General Practitioners
Dr Mark Newbold chief executive, Heart of England Foundation Trust
Ali Parsa former chief executive of Circle – but attending in a personal capacity
Jeremy Taylor chief executive, National Voices

R FRANCIS'S EPIC



Debating Francis (clockwise from top left): Peter Carter, Harry Cayton, Niall Dickson, Nigel Edwards, Gerard Hanratty and Mark Newbold





happen overnight. However, he cited New York's approach to rubbish collection – where residents had felt empowered to take photos of uncollected rubbish and upload them to a website – as an example of transparency driving change.

And Ruth Holt, director of nursing at the NHS Confederation, highlighted the focus on the culture of care. "You could summarise the whole document into one sentence – it is that we have lost that focus on caring. We need to get that back."

As the chief executive of an acute trust, Dr Mark Newbold had a keen interest in the report. But he admitted to being disappointed: "It is like seeing the right label on the door and when you open the door there is nothing in there."

'A lot of what is in the report is already being done somewhere in the NHS'

He praised the focus on public involvement with local organisations: "It is a good way to make change to bring the public in. We have to pick up the themes and work out how to change them in practice."

But he said there was a conflict between an obligation to listen to and respond to the public's wishes ("Don't close that A&E," quipped Mr McLellan) and the strong central drive. He was not currently empowered to adopt the local drive because of the statutory obligations on his organisation.

RCN general secretary Peter Carter said many people had too much enthusiasm for the regulation of healthcare assistants as a means to change things. "But the compulsory education and training of healthcare assistants will go a huge way to ameliorating what we see across the country."

And he welcomed recommendations that ward nurse manager should be supernumerary, helping them to have an overview of the ward, and that trust boards should be encouraged to really understand staffing needs.

But some of the panellists' reservations about the report came out when Mr McLellan asked what was missing from the report, they felt was wrong or felt the NHS should not adopt.

Mr Hunt was concerned by the focus on data: there was already much data which did not make sense. "I have doubts that more information will shed much more light," he said. Mr Dickson pointed out a lot of what was in the report was already being done somewhere in the NHS: there was a need to identify good practice and what makes good organisations different from others. "I think regulation has a limited role," he added and there was a danger of too much regulation – and a suppression of local initiative – if Francis were adopted in its entirety.

Duty of candour

The duty of candour also drew some mixed views. Mr Hanratty said it was not particularly well thought out and he was concerned about individual doctors and nurses, as well as organisations, facing criminal sanctions. "It concerns me that it will drive people out of the professions," he said.

There were already criminal sanctions relating to some forms of poor care but they were not used and were not well understood, he added.

Dr Newbold said that he found professionals were often nervous about being open in complaint cases because they feared sanctions, and greater sanctions would make them less open. "I do fear that making it criminal will potentially cause people to close up even further and work against an open culture."

But Mr Taylor said under the

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‘Regulation has failed yet the report says more regulation is needed; the blame culture should be ended but more punishment is needed’

GERARD HANRATTY ON THE IMPACT OF 1,900 PAGES

The report should be seen as a symbolic representation of a crisis point, or staging post, being reached in the NHS that needs to be addressed openly and transparently. The reason it is not a game changer, subject to your definition of the phrase, is because of its view that cultural change in the NHS is key, an issue addressed by Kieran Walshe in his 2003 report *Inquiries: learning from failure in the NHS?* (Nuffield Trust). He wrote: “Many of the common problems… are largely cultural in nature, but it is difficult for inquiries to make concrete recommendations for change in this area. Instead, their prescriptions are often structurally focused, proposing new procedures and systems.”

Certainly, in considering that the full report runs to over 1,900 pages, including the executive summary, and that there are 290 recommendations, then how many will read it all and understand all the recommendations?

If you consider the above view on cultural problems, then reflect on the legal and regulatory nature of the recommendations made and consider the seismic change ongoing in the commissioning landscape, then it is obvious why the report should be viewed as a staging point on the way to change and not a game changer in itself.

‘Cultural change is much bigger than one person’s recommendations’

It is important to appreciate that the report will, undoubtedly, add impetus to the change agenda and introduce discussion on issues that may not have been prominent on the NHS radar – but cultural change is much bigger than one report or one person’s recommendations.

Francis’s report will give impetus to drive the change many believe is needed to re-ignite public trust and confidence in the NHS. It will also be important for the NHS to take control of the discussion on change and not allow it to be a media-driven political football, which all too often appears to be the norm for issues about the NHS. The public needs to understand the NHS does not have an open cheque book and that effective use of the money available will mean looking at the efficient use of resources to deliver the best quality clinical care that can be achieved.

It is to be hoped that the report leads to the development of greater understanding and involvement between the NHS and the public.

Gerard Hanratty is a partner at Capsticks

current system people found it very hard to find out what had gone wrong. He said the duty of candour would be a change in the law which might have a symbolic importance. Mr Edwards suggested that Francis saw the duty as a culture change and might not expect there to be many prosecutions. “I think there might be other, better ways of getting people to be more candid.”

Mr Dickson added: “Would one want to be a non-executive director in an NHS trust if you faced the anxiety of someone raising this?”

The duty of candour existed in professional regulations and had been enforced, he added. “If you are trying to change the culture, putting the fear of God into everyone is not necessarily the way.”

But Mr Parsa felt that people should have some personal responsibility for poor care in hospital as well as institutional responsibility: “They can’t just sit back and say sorry, it was the managers’ fault”

There were also other elements of the report that the panel had concerns about. Nigel Edwards highlighted how there had already been changes to regulation, patient and public involvement, and the complaints system. He questioned the understanding of culture and how to change it – and the assumption that the NHS had a single culture.

‘By the time someone has been judged not “fit and proper” they are likely to have already done something seriously bad’

Mr Taylor suggested the report lacked the notion of opportunity cost – while organisations were implementing it, other things would not get done.

And there could be unintended consequences: Dr Newbold could see trade-offs between resources being put into the “acute front end” of hospitals – where many of the problems Francis had identified had been – and the ability to sustain specialist services at so many sites.

Mr Taylor also felt the concept of patient and public involvement in the report was paternalistic and lacked democracy. “He has identified a problem which must be addressed but not necessarily in the way he suggests,” he said.

Revalidation of nurses is one of the key recommendations but Ms Holt was concerned that the short timespan hinted at in the report could make it superficial rather than meaningful: doctors’ revalidation had taken a very long time to get into place.

And Mr Carter pointed out that the call for student nurses to spend three months getting hands-on experience ignored the existing structure of nursing courses, where they already spent half their training in healthcare.

A key recommendation about selecting student nurses for

Clockwise from top left: Neil Hunt, Ruth Holt, Alastair McLellan, Jeremy Taylor and Ali Parsa

attitude and values also ignored reality. Student nurses were already "bright-eyed and highly enthusiastic" but compassion could be drained out of people. "The people who come before the NMC are not 22- and 23-year-olds... they are nurses with 15, 20 and 25 years experience," he said.

Mr Cayton could see many inherent contradictions in the report: that regulation had failed but more regulation was needed and the idea that the blame culture should be ended but more punishment was needed. "We need to build on good professionals' sense of responsibility," he said.

There was also scepticism about the "fit and proper person" test that has been suggested for board members, which Mr Edwards described as "a backstop which might help a little bit", while Jeremy Taylor suggested it was one of the points in the report which should be thought of symbolically. Harry Cayton pointed out: "Presumably banks had a fit and proper person test... that has not really worked."

Mr Edwards suggested that by the time someone had been judged not to be "fit and proper" they were likely to have already done something fairly seriously bad. Previous employers needed to be open about people – although other panel members pointed out that employers were often advised to give very bland references which only confirmed facts. This could lead to people being "recycled" through the system. Mr Hanratty emphasised the importance of information sharing and suggested the NHS sometimes made this more complex than the legal position actually was.

Mr Taylor added that there was also a danger of making it too onerous for lay people to become foundation trust governors.

Mr Hunt pointed out some of the problems for doctors around soft data that might suggest, for example, performance issues: what should be done with it? Mr Dickson stressed the importance of having a good clinical governance system in place and said that revalidation was a step on that road. Dr Newbold added that trusts should be obliged to publish quality data in a standardised way.

Finally, Mr McLellan invited the panel to get their crystal balls out and say what they thought would be the legacy of the Francis report in 2018.

Mr Dickson said he hoped to see greater alignment between professionals' and organisations' ambitions and goals. An outcome would be the reconfiguration of some – but not all – unviable hospitals and institutions and a shift towards quality and safety being at the centre of everything the NHS did. "I think we have made some progress and will make some more progress. But the downside is that the money will get more difficult and that pushes against all this stuff," he said.

Mr Hanratty said if involvement of the patient and public improved as a result of Francis it could help drive through some reconfigurations. But he said there was a need for clarity over the roles of commissioners and regulators.

But Francis is not happening in a vacuum and Mr Edwards pointed to the environment in which changes would have to occur and the general direction of policy.

"You are a prisoner of the decisions that we have already taken," he said. "The things that are in line with path-dependent change now will happen, [and] we will get more of." But where the recommendations were at 90 degrees to the existing direction of travel – such as around regulation and those requiring legislation – they were less likely to bring about change, as it depended on whether parliament and politicians would deliver this.

The Francis report was unlikely to be an inflection point which radically changed the existing direction of policy, he said. It would instead be more of a lodestar or a reference point which people used to defend positions and decisions, rather than individual recommendations being cited.

Mr Cayton stressed the importance of aligning system and professional regulation, which he thought could happen.

Mr Taylor had three scenarios. In the most optimistic one, the report did provide a tipping point towards a culture of caring and openness. However, in the most pessimistic, the implementation of Francis held up reforms for about two years.

Effects of austerity

But the scenario he thought most likely was that austerity would be the big driver: the government would present the policies it was going to introduce anyway as its response to Francis.

"If you see a snake, you kill a snake, you don't form a committee on snakes," was Mr Parsa's pithy comment on the report. He thought the culture could change – but that was not something in the gift of the report. A generational shift would also mean less acceptance of poor care.

"There is something for me about quality and safety which is rising up all board agendas," said Ms Holt. Increasing professionalism of healthcare assistants would also happen, and governors and members in foundation trusts would get more of a voice.

Dr Newbold said: "I think reports like Francis will be effective not because of what is written in them but because the symbolism of it taps into what is happening and what people are thinking. The genie is out of the bottle in terms of principles and values being more important in how we administer and manage the health service."

He could see some benefits resulting from the report. People would be braver about speaking out and there would be a clearer consensus about what was important.

The report would also close the engagement gap between managers and the frontline, and the system would move from being access-driven to grappling with issues around values, priorities and care standards. "It won't happen overnight and cleanly, and it will be messy and slow and patchy, but we will hear those voices more strongly," Dr Newbold predicted.

Mr Hunt thought commissioners would be much more focused on good outcomes.

Changes to the training and education of the 300,000 healthcare assistants in the NHS would be influential, suggested Mr Carter.

He also pointed out that one of the previous directors of nursing at Mid Staffordshire had said they did not see standards of patient care as being their responsibility. "I hope that we never get a situation where any director of nursing has some idea that fundamental standards of care isn't what their primary role is," he said. ●

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