

Mid Staffordshire NHS Foundation Trust
Public Inquiry Report

**Response of the
Royal College of Nursing**

Executive summary

The Francis report, following the public inquiry into failings at Mid Staffordshire NHS Foundation Trust and those of regulatory bodies, represents a watershed moment in the history of our health service.

In this document, the RCN has sought to respond to many of Robert Francis' 290 recommendations on what the NHS and the independent sector must do to ensure the failings at Mid Staffordshire are never repeated. We have sought to follow the same themes and structure that Robert Francis used in his seminal report, and have outlined our position on key recommendations, the work we have already undertaken and the important steps that need to be taken next.

Robert Francis discussed the role of the RCN in his report and highlighted that we could have done more locally to support our members on the ground. This is something that the RCN readily acknowledged in its initial response to the report (6 February 2013). Recommendation 201 of the Francis report suggests that the RCN should consider formally splitting its employee representation (trade union) function from the professional function. The RCN has discussed this with our membership on numerous occasions, most recently at RCN Congress in April 2013. At that meeting, 99 per cent of delegates expressed a wish to maintain the RCN's current structure, and members repeatedly spoke of how they believed the relationship between our trade union and professional functions makes the RCN a stronger organisation. We believe, however, that there is more we can do to improve how these two sides interact and we will begin work in earnest to explore how to make this a reality.

The role of the named nurse and a move towards patient-centred care were both included in the Francis report. The RCN is not opposed to the named nurse idea, but the reality is that there are often too few nurses on the ground to make such a project work in reality. With appropriate staffing, however, the RCN would be supportive of such a move. As we explain in the relevant chapter, Robert Francis is right to demand a shift towards patient-centred care. The burden is now on NHS employers to give nursing staff the time, resources and support to deliver on this worthy ambition.

Robert Francis rightly demands a shift from task-focused care to patient-centred care, and the RCN agrees wholeheartedly. One main reason for a focus on putting the task before the patient has been the dilution of skill mix across the health service, with health care support workers being used to undertake the work of registered nurses.

One of the most significant themes in Robert Francis' report is the impact of culture on the practice of organisations and staff. At Mid Staffordshire, there was an obvious disconnect, a gulf in communication between those on the trust board and those on the ward. A focus on unnecessary targets (often financial) meant that patients were sometimes not seen as the vulnerable human beings they are. Therefore we fully support Robert Francis' recommendation for a shared culture in which "the patient is the priority in everything done".

When a culture is not right in an organisation, it has an impact on the professional attitudes and behaviours of the staff who work for it. Put simply, a toxic culture can pollute good people. The RCN acknowledges that a very small but distinct minority of staff in the NHS exhibits attitudes and behaviours that are detrimental to patients. However, despite the rhetoric of some commentators, we do not believe that this is linked in any way to nursing students. On the contrary, poor behaviours and attitudes are often exhibited by staff who have worked in the NHS for decades. The RCN believes that the NHS often sets up good people to do bad things; through constant change, chronic under-staffing and unrelenting pressure, staff have kindness and compassion eroded from them. As we explain in this document, more must be done to tackle the burnout associated with the constant emotional labour of caring and to support staff who chose to give their working lives to our NHS.

Poor practice is not just about delivering poor care to patients; it is also about not doing enough to prevent poor care in the first place. Robert Francis recommended a new duty of candour that would oblige staff and employers to speak out when mistakes are made and which could have a negative effect on patients. He recommended that this duty should be legally enforceable and that criminal sanctions should apply to those who seek to obstruct staff in raising the alarm. The RCN supports many of the recommendations relating to the need for staff to speak out when they see poor care. However, we do not believe that there is a need for new criminal offences in relation to the statutory duty on individuals. We believe that a requirement to disclose information on acts or omissions in care is already provided by the Nursing and Midwifery Council code of conduct – part of a legal framework of accountability. Furthermore, we believe that such a move would be counter-productive to the ambition to improve openness and transparency in the NHS, and could in fact result in an even greater culture of fear.

The RCN does believe that all staff have a responsibility to raise concerns regarding poor care and the pressures that may eventually lead to poor care. We have recently revised key guidance for our members on the necessary steps they should take when they need to raise concerns.

One of the most debated recommendations in the Francis report relates to a proposal that would-be nurses should, for up to three months, work “on the direct care of patients under the supervision of a registered nurse”, the completion of which would be a precondition to the continuation of nurse training.

We firmly believe that the 2,300 hours that student nurses currently spend on clinical placements is sufficient preparation for the world of practice and patient care. Furthermore, there is no evidence that newly qualified nurses are exhibiting any behaviours that should give rise to the kind of concerns that would warrant such a radical change to the current system. The Willis Commission on the future of nursing education concluded that there were “no major shortcomings” in the way in which we train our nurses of the future – a view the RCN shares.

However, we understand that there may be room for improvement in nurse education. The RCN supports Robert Francis’ recommendation that we must recruit student nurses who exhibit the right values, display a desire to deliver compassionate care and learn the technical skills essential to modern-day nursing. Furthermore, we must continually evaluate the success of mentorship and preceptorship experiences, which are vital to the development of future nurses. While not addressed directly by the inquiry report, the quality of practice placements, the relationships between providers of care services and higher education institutions, and the degree to which employers support lifelong learning are all essential contributing factors towards producing a skilled, motivated and valued workforce.

As Robert Francis rightly identifies, one of the most significant factors in the failings at Mid Staffordshire was a lack of leadership. This deficit applied to the board, middle management and to those leading wards. The RCN believes that nursing requires strong leadership in all echelons of the health service. We therefore support the recommendation for the continued role of the chief nursing officer. The RCN has long campaigned for nurses in positions of leadership, including the establishment of the director of nursing post. We therefore support the recommendation for increased opportunities for the multi-professional education of

leaders, managers and indeed nurses. Importantly, the RCN supports Robert Francis’ emphasis on the role of the ward sister being crucial to the quality of the patient experience. The RCN has long called for the ward sister role to be given improved recognition and to be freed from clinical duties so that the individual can lead, teach and mentor staff.

In terms of the biggest priorities for the NHS in the next decade or so, few are more important than improving the quality of care delivered to older people. This group was let down badly at Mid Staffordshire, and we have seen similar instances of poor care in both NHS and independent care settings in recent years. The RCN believes that the whole care team has a role to play in delivering excellent care to older people. The delivery of good care to older people should not be viewed separately from the other challenges facing the NHS. Older people have significant care demands, but the current approach to staffing levels in this area is simply not recognising this. The RCN believes that mandatory safe staffing levels, the regulation of health care support workers and the delivery of consistent training will all lead to improvements in the care of older people.

The RCN believes that we need nationally recognised career pathways for those wishing to develop their skills in older people’s nursing at the post-registration stage, and that all those seeking to be a nurse understand how to deliver excellent care to older people.

It is not just the delivery of excellent frontline care that affects the patient experience; we know that the quality of record keeping, and how the information is then shared, matters too. The RCN broadly welcomes the recommendations made by Robert Francis and believes that the recent Caldicott review of information governance in health and social care offers excellent advice on how to improve the exchange of information between providers and their patients.

Of the numerous factors that lead to poor care, few are more important or powerful than unsafe staffing levels. Painting a stark picture, a recent report from the Centre for Workforce Intelligence highlighted that nurse numbers could fall by 11 per cent, or 63,800, in England by 2016 (CfWI, 2013).

The RCN’s own analysis, most notably through our Frontline First campaign, has shown continued cuts to nurse posts since 2010. Despite this, there is a wealth of evidence (highlighted below) that shows a link between the patient experience and the number of nursing staff on the ground.

The RCN believes that the time has come for health policy to address the importance of this relationship. The RCN supports Robert Francis' recommendations around staffing levels, including metrics developed by the National Institute for Health and Care Excellence (NICE) and used by the Care Quality Commission (CQC), but we do not believe these measures go far enough. The RCN believes that the UK must follow the lead set by other countries, including Australia, and enshrine mandatory safe staffing levels in law. Establishing a range of such levels would be based on current evidence and patient dependency, and should be responsive to local need, but would offer the legal protection that patients deserve.

The RCN believes that this is one of the most important issues facing the NHS. Failure to tackle unsafe staffing would be to fail patients entirely.

Approximately a third of Robert Francis' 290 recommendations relate to the regulation of the health care system. The RCN supports the use of expert inspectors, and urges the newly appointed chief inspector of hospitals to draw on existing clinical expertise within the CQC, specifically the national clinical advisers. The RCN supports proposals for a planned and incremental "merger of system regulatory functions between Monitor and the Care Quality Commission" (recommendation 64) but there are concerns about the increase in workload being demanded of both organisations. We believe there is a need for consolidation of the changes to both organisations that are already in progress. Both the CQC and Monitor will require new resources and skills to tackle the significant challenges that face them, and both would benefit from a greater degree of nursing input.

Robert Francis also made recommendations regarding the Nursing and Midwifery Council (NMC). In particular, he identified the largely reactive nature of the NMC's work and proposed that, instead, the NMC should be able to launch proactive investigations if there is a concern regarding nursing fitness to practise. Although the RCN supports such a move in principle, it will only be possible through greater collaboration with health system regulators, notably by sharing information with the CQC.

In recent years, the NHS and the independent sector have become increasingly reliant on health care support workers (HCSWs). HCSWs are crucial to the delivery of patient care, but the problems that face this part of nursing must not be underestimated. Current training is inconsistent and HCSWs who are challenged for delivering poor patient care

can simply move from one employer to another because of a lack of mandatory regulation. The RCN strongly supports Robert Francis' recommendations on the role of HCSWs, particularly that of mandatory registration and eventual regulation. We know that hundreds of thousands of HCSWs are delivering essential care to patients, including many older people, and yet there is no central register of who they are, the training they have undertaken and where they have worked previously. The RCN believes this has to change. The mandatory regulation and training of the UK's HCSWs is one of the most critical steps the Government can take to ensure the delivery of safe care to patients.

As can be seen in the pages of this document, the RCN has undertaken significant work already in the many areas identified by Robert Francis. As the professional voice for nursing, we do not underestimate the significant challenges that face all those who deliver care for patients, both directly and from management positions. This formal response is only one part of a broad spectrum of work that will be undertaken in the months and years to come.

Robert Francis has set out a clear direction for the future of the health service; the onus is now on all of us to make sure we follow it.

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Notes



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W1G 0RN
020 7409 3333
www.rcn.org.uk

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