



Putting
patients
first:
realising
Francis'
vision

Royal College of Physicians' response
to the final report of the Mid Staffordshire
NHS Foundation Trust Public Inquiry

Introduction

When he launched the final report of the Mid Staffordshire Public Inquiry, Robert Francis stated:

*'What is required now is a real change in culture, a refocusing and recommitment of all who work in the NHS – from top to bottom of the system – **on putting the patient first.**'*¹ (Our emphasis.)

In *Putting patients first*, the Royal College of Physicians (RCP) highlights how we are responding to the final report of the Francis Inquiry. Here, we discuss doctors improving culture through leadership, higher standards for patients, maximising doctors' skills and improving their training, supporting doctors to raise concerns, better systems for patient care and the government's response to Francis so far.

The RCP has also produced a longer document that provides further details on the work we are doing in this area.² The RCP commits to reviewing all actions in this document annually.

Foreword

Responding to Francis – a particular challenge for medicine

My involvement with the Francis Inquiry¹ over the past three years has been distressing, challenging and thought-provoking. Francis' recommendations are far reaching. Many of the instances of substandard care took place in medical wards caring for our most vulnerable patients: frail older people with complex comorbidities. Achieving 'gold standard' care for this group must be the priority: it will make a substantial contribution to ensuring that the events at Mid Staffordshire are never repeated.

This response to the Francis Inquiry has attempted to address both how the care system can be better designed to facilitate high-quality, compassionate care and how individual doctors need to re-evaluate their professionalism in the light of the Inquiry's findings. Francis' vision of the patient at the centre of everything the NHS does forces us to reconsider our own actions as individuals and as a body of professionals, and leaves no room for complacency.

Dr Patrick Cadigan

RCP registrar and lead officer for the Francis Inquiry

Responding to Francis – putting the patient first

The first rule of medicine is to do no harm. Unfortunately the events at Mid Staffordshire Foundation Trust show us that too often patients are harmed while in the care of the NHS. The Francis Inquiry offers us a watershed moment in patient safety. In their response to Francis, the RCP has set a challenge to their members: they must contribute to a culture of openness and transparency by ensuring that their hospital embeds and learns from patient experience, and by adopting leadership qualities in all that they do.

But doctors must be helped by the system they work in to provide the best possible care. I understand doctors' frustrations if badly organised systems mean that the standard of care they want to provide becomes impossible.

Suzie Hughes

Chair of the RCP's Patient and Carer Network

‘The challenge for the system is to identify a means of ensuring a common culture of positive values and methods prevailing over, and driving out, negative values and methods.’ Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Vol 3 p1,357

Improving the culture – doctors as leaders

Robert Francis identified a culture at Mid Staffordshire NHS Foundation Trust that did not put patients at the centre, prioritise patient safety or embrace openness and transparency. The RCP believes that more and better clinical leadership is the key to adopting a culture throughout the NHS that delivers high-quality care for patients.

All doctors are leaders; they all manage patient care, and registrars and consultants manage clinical teams. Where a clinical team includes a doctor, he or she takes ultimate responsibility and consequently the team leader is usually the doctor.³ The RCP’s flagship publications, *Doctors in society*⁴ and *Future physician*⁵ identified leadership as a core part of a doctor’s professionalism. Medical leadership can be defined as anything a doctor does to improve patient care and patient outcomes. Doctors who are leaders value patient experience as highly as clinical effectiveness. In practice, this means the doctor is responsible for holistic care of the patient. Consultants need to regard promoting dignity and good basic care throughout the patient pathway as fundamental to their work.

Developing leadership skills among doctors

The RCP, via the Joint Royal Colleges of Physicians Training Board (JRCPTB),⁶ works to ensure that leadership is part of doctors’ curricula. With the Academy of Medical Royal Colleges we have developed the Medical Leadership Competency Framework (MLCM)⁷ that ensures that elements of leadership are part of the physician curriculum and describes leadership competencies for doctors, which include improving services and setting direction.

The RCP has developed and delivers a number of medical leadership training and education programmes for both senior and junior doctors. These include an MSc in Medical Leadership, specific programmes for educational supervisors and programmes directed at senior trainees.

Following an initiative by the RCP, the Faculty of Medical Leadership and Management (FMLM)⁸ was formed by the medical royal colleges to create a professional home for those doctors carrying out, or aspiring to, formal management roles within the NHS. The Faculty is the guardian of the MLCM.

New initiatives from the RCP to develop leadership among doctors

While the RCP already does a great deal to develop leadership competencies among doctors, we shall improve the emphasis on leadership within doctors’ training and continue to work

to engage doctors in leadership training above and beyond what they learn in their curricula. We shall seek to ensure that leadership competencies are reached around awareness of the vulnerable, which includes older patients. The RCP will continue to work with the FMLM and in particular, starting in September 2013, we will be sharing a clinical fellow who will work on taking forward the FMLM’s and the RCP’s work in this area.

Helping to improve patient experience

The RCP’s National Clinical Guideline Centre (NCGC)⁹ recently published guidance and quality standards on patient experience to improve patient-centred care and facilitate shared decision-making between patients and clinical staff.¹⁰ The guidance is directed to all staff involved in providing NHS services. Quality standards include:

- > knowing the patient as an individual
- > understanding the essential requirements of care
- > tailoring healthcare services to each patient
- > continuity of care and relationships
- > enabling patients to actively participate in their care.

The RCP and NCGC will continue to promote the guidance and quality standards on patient experience and commit to regularly reviewing the recommendations.

To further embed patient experience, the RCP has recently appointed a clinical fellow for shared decision-making to develop a work programme around clinicians working in partnership with patients to achieve the best outcomes of care. Patients and their carers have a direct interest in the care that they receive and the decisions that are made in relation to their health. They bring a personal perspective to all these decisions about their care that is key to the right decisions being made for them, and that can easily be overlooked. Furthermore, patients who are more involved in these decisions have better outcomes.

Therefore, the RCP will take the following actions.

Action	Timescale
> The RCP will continue to engage all trainees in developing leadership skills in their medical practice.	Ongoing
> The RCP will continue to communicate the values of doctors’ professionalism, in particular leadership responsibilities.	By end of 2013
> The RCP and Faculty of Medical Leadership and Management will continue to work together in supporting doctors to develop leadership skills and management roles.	Ongoing

Action points continued overleaf >

‘The system of standards in the NHS is in a state of evolution but there is evidence that essential standards are not yet effectively adopted on a universal basis.’ Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Vol 3 p1,399

Action	Timescale
> The RCP and National Clinical Guideline Centre will continue to promote the guidance and quality standards on patient experience and commit to regularly reviewing the recommendations.	Ongoing
> The RCP will develop the shared decision-making work programme within the RCP and promote the findings to key stakeholders.	Ongoing

The RCP also supports our members and fellows to take part in quality improvement programmes. Our ‘Learning to make a difference’ programme aims to support trainees in core medical training to undertake a quality improvement project annually during their training.

RCP quality standards

As previously mentioned, the RCP has produced patient experience guidance and quality standards.¹⁰ As far as we know, this is the first set of quality improvement standards that focus on patient experience. The RCP has also produced standards for patient records.¹⁵ They have been endorsed by 50 bodies. However, for the benefits to patients of electronic patient records to be fully realised, these professionally developed and agreed standards should be the basis for the integrated digital care record and electronic communications between healthcare settings. We want to see patients having access to their electronic hospital records to improve shared decision-making and to support patient self-management.

The RCP agrees with Francis’ recommendation regarding embedding quality improvement in commissioning. We want to help facilitate this. We hope that better information to enable quality improvement to be embedded in commissioning, and a better understanding of the wider health economy among physicians, will be achieved by the RCP’s Clinical Commissioning Hub, which was launched in June 2013 and currently sits on the RCP website.¹⁶

A key part of the Hub will be *Consultant physicians working for patients*, a flagship RCP publication that brings together information about all 30 physician specialties.¹⁷ In the light of the publication of the final report of the Francis Inquiry, the RCP will review the purpose of the document to assess the quality and comprehensiveness of the information, how best to disseminate it, standards, workforce requirements and job plans for medical specialties.

Advice on quality improvement

The RCP is well placed to offer advice and information on clinical standard setting. This includes measurement through audit, interpretation of results, and support to plan and implement quality improvement. Our clinical consultancy and support services are delivered on a local, national and international scale. A specific example includes invited service reviews (ISRs),¹⁸ in which organisations can gain external and independent advice from the RCP on any issues that are proving difficult to resolve. ISRs can be organised for any specialty, in any part of the UK.

Higher standards for patients

The RCP’s core function is to improve quality across the NHS. The unique contribution we make to this is through the influence of physicians on quality, standards and training. This is done, in part, by our guidelines and clinical standards work programmes, including audit and accreditation. No other organisation conducts as many quality improvement audits for the health sector; details are on the RCP website.¹¹ The RCP’s domains of quality are adapted from internationally recognised domains of safety, effectiveness, patient experience, equity, efficiency, timelines and sustainability. The RCP’s Quality Strategy¹² is based on the core principles of quality improvement: setting standards, measuring against these, working to improve quality, and then measuring again.

RCP quality improvement programmes

The RCP conducts a large number of quality improvement programmes that help to drive up standards. We conduct over 20 clinical audits, a key example being the RCP’s flagship stroke audit. Individual hospital reports are provided to chief executives and non-executive board chairs, and results and participation are published. The RCP’s stroke audit helped to inform the successful reorganisation of stroke services in London. The RCP also conducts a service accreditation programme.¹³ The RCP is proposing that a common framework for accreditation standards be developed to apply across all clinical specialities. Common areas should include clinical quality, patient experience, safety, facilities, and workforce and training.

The RCP is keen to develop more accreditation programmes and to consider patient pathways, rather than discrete patient services. The three proposed elements are:

- > acute medicine
- > longer-stay care; this will include the Elder-friendly Ward Quality Mark Programme¹⁴ that will award a quality mark to elderly-friendly wards – see page 5 for more information
- > longer-term conditions.

*Conducted jointly with the Joint Royal Colleges of Physicians’ Training Board (JRCPTB) and Health Education England.

New initiatives from the RCP to set higher standards for patients

Realising Francis' 'three tiers of standards' recommendation

The RCP welcomes Francis' recommendations that there be three tiers of standards that are commonly understood across the healthcare system: fundamental, quality and developmental. The RCP proposes to bring together all stakeholders in the standards field to agree definitions of the three tiers of standards and identify organisations to lead those developments. The seminar will include patient representatives.

Elder-friendly Ward Quality Mark

Many of the instances of substandard care that Francis identified in both in the independent¹⁹ and public inquiries¹ relate to the care of older people, often with complex needs including dementia. The RCP believes the priority in the NHS is improving standards for this group: if the NHS gets care right for vulnerable older people, the most difficult group to manage, then we believe care is likely to be improved for most other patients.

The Elder-friendly Ward Quality Mark programme provides a quality mark to general hospital wards that provide high-quality care for older people.²⁰ This quality mark programme is voluntary, subscription-based and open to all wards. The RCP believes that a quality mark for wards will help to address the bad practice identified by Francis that resulted in substandard care. For example, the measures include a questionnaire gathering feedback from older patients directly about the quality of essential care. Following a pilot, the programme is being rolled out with the first quality mark expected to be awarded in 2014.

Hospital Health Check

The RCP holds data on many key aspects of the medical workforce, education and clinical performance within trusts. These data are available at different levels (eg individual, hospital trust, regional) and aggregating them has not been attempted before. For the first time, the RCP is mapping these data across departmental boundaries, at hospital or trust level, with the aim of providing an overview of a given organisation and its physician-based workforce. The Hospital Health Check includes data about trust participation in national clinical audits and quality improvement (QI) programmes, MRCP(UK) activity (membership examination), and consultant physician workforce demographics, clinical time, morale, and retirement plans. Robust, publicly available external data will also augment RCP data. The RCP is currently piloting this work.

Therefore, the RCP will take the following actions.

Action	Timescale
> The RCP will work with partners to develop aligned accreditation services.	Ongoing
> The RCP will work with key stakeholders to embed patient experience quality standards into best practice.	Ongoing
> The RCP will develop and maintain a Clinical Commissioning Hub, which will support doctors and others in their new roles as commissioners.	Launched in summer 2013, ongoing

Maximising skills, improving training, supporting doctors

The RCP improving doctors' education and training

The Francis report makes clear that education and training should not take place in clinical locations that do not comply with fundamental patient safety and standards. The RCP fully agrees and, through our work setting the curriculum for doctors and examining them, wishes to use the Francis Inquiry as an opportunity to review how to deliver high-quality training and assessment which is consistently delivered and coordinated across stakeholder groups, supports physicians, and delivers the best and safest patient care.

The RCP is reviewing doctors' education and training to ensure that it will continue to meet patients' needs as they change in the future, due to demography changes for example. The RCP believes that doctors should be trained to provide holistic care, to be professional, to understand concepts such as risk management, and to be able to assess research evidence. Holistic care includes taking responsibility for aspects such as compassion, dignity, pain relief, hydration and nutrition. More (general) internal medicine experience in different settings may help to deliver this. The RCP is currently highlighting these messages to the Shape of Training review,²¹ which is looking at potential reforms to the structure of postgraduate medical education and training across the UK.²²

The RCP believes that royal colleges should have a more formal role in quality assurance for education and training, and sees

'Good practical training should only be given where there is good clinical care. Absence of care to that standard will mean that training is deficient ... there is an inextricable link between the two that no organisation responsible for the provision, supervision or regulation of education can properly ignore.' Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Vol 2 p1,258

‘A ward for the elderly should be a calm, clean and comfortable environment, in which patients receive the help they need, when they need it, with the aim of maximising their prospects of recovery.’ Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Vol 3 p1,610

this as synonymous with high-quality of care. We propose developing a system to identify a pool of physicians who are able and willing to accompany the General Medical Council (GMC) on their education visits, as recommended by Francis. The RCP will also work with deans and directors of medical education and training, to contribute to the quality assessment and management of trainee posts and press for the dean to sit on the Local Education and Training Boards and be responsible directly to the managing director.

RCP support for doctors who have concerns

The RCP believes we have a duty to provide members and fellows with support if they have concerns about the standard of care in their hospital. We have developed and piloted a model of ‘regional conversations’ in the West Midlands and other parts of the country. The aim of these conversations is to provide a safe space for consultants to discuss with regional advisers from the RCP any concerns they have about the hospital in which they work, and the care provided there. This information is then formally fed back to the medical director of the trust by the RCP’s registrar and there is further follow-up if necessary. The RCP proposes that once the pilot has been evaluated, the scheme is rolled out across England and Wales.

The RCP will develop information about how to raise concerns and provide this to our members. This information would explain the roles and responsibilities of all individuals (such as medical directors) and organisations (such as deaneries and the Care Quality Commission (CQC)) that have a responsibility for quality and patient safety, and make recommendations on steps to take when doctors have a concern. The RCP sees revalidation as having a role in helping doctors to raise concerns, and proposes that concerns could be shared in annual appraisals (for nurses also) and should be encouraged and supported by appraisers. These should be seen as a positive action.

Therefore, the RCP will take the following actions.

Action	Timescale
> The RCP will review how to deliver high-quality training and assessment which supports physicians and delivers the best and safest patient care. This includes reviewing its examinations to ensure that competencies about raising concerns and treating patients with dignity are included.	Ongoing
> The RCP will work with deans to contribute to the quality assessment and management of trainee posts and support the role of deaneries.	Ongoing

Better systems for high-quality patient care

A crisis in acute care: time to take action for patients

In December 2010 the RCP recommended for the first time that any hospital admitting acutely ill patients should have a consultant physician on site for at least 12 hours a day, 7 days a week, who should have no other duties scheduled during this time.²³ All medical wards should have a daily visit from a consultant; in most hospitals this will involve more than one physician. Patients become acutely ill 7 days a week and the NHS must change to meet the needs of patients out of normal working hours. The RCP believes this will considerably improve patient experience, particularly for those with long-term conditions.

Since the publication of this statement, the RCP has produced an acute care toolkit on 7-day working.²⁴ It provides practical guidance to senior hospital managers and clinical staff on how to organise acute medical services to ensure that the 12-hour consultant presence delivers consistent high-quality care to acutely ill patients.

The RCP examined the pressures faced by acute care in *Hospitals on the edge? The time for action*, published in September 2012.²⁵ The report brought together evidence showing that these pressures are relentless and intense and are caused by the following issues:

- > increasing clinical demand
- > older patients with more complex needs
- > fractured care
- > out-of-hours care breakdown
- > looming workforce crisis in the medical workforce.

The RCP has also been working with the NHS Confederation (the membership body for all organisations that commission and provide NHS services),²⁶ the Society for Acute Medicine²⁷ and the College of Emergency Medicine²⁸ to develop recommendations on urgent and emergency care services.²⁹ The recommendations were launched in July and include:

- > developing effective and simplified alternatives to hospital admission across 7 days
- > focusing on supporting patients to leave hospital 7 days a week
- > organising high-quality consultant-led hospital services across 7 days.

To address these issues fully and to contribute to helping the hospital system to deliver safe, high-quality and seamless care, the RCP established the Future Hospital Commission.

Redesigning the hospital system to facilitate high-quality, compassionate patient care: the Future Hospital Commission

The RCP established the Future Hospital Commission (FHC) in March 2012 to review all aspects of the design and delivery of inpatient hospital care.³⁰ It is chaired by Professor Sir Michael Rawlins and reports in September 2013. The FHC involves patients and professionals from across health and social care and it aims to explore organisational structures, processes and standards of care, focusing on five key areas:

- > patients and compassion: leadership, responsibility and compassion on the wards and the operation of multidisciplinary teams
- > place and process: patient pathways and the balance between generalist and specialist care
- > people: composition and development of the medical workforce, and interaction between medical and other teams
- > data for improvement: use of patient records, medical information and audit
- > planning infrastructure: organisation of diagnostic, support and community services.

The FHC is reviewing many of the themes highlighted by the Francis Inquiry, such as improving hospital care for older people and improved team-working for those responsible for healthcare provision. This means that the RCP will provide timely and significant directions for healthcare providers and recipients of care. The RCP is committed to ensuring that the FHC considers the recommendations of the Francis Inquiry and incorporates them into the Commission's final report.

Following the publication of the FHC's final report, pilot sites will be identified to enable best practice and lessons to be shared. As part of the next phase of work, the RCP is considering whether it should investigate how secondary and community health services, primary care, social care, mental health, secondary care and the voluntary sector can better work together to meet the needs of patients. The RCP sees the FHC not only as a report but as a means to implement many of Francis' recommendations, especially those relating to compassion and coordination of care. For example, the RCP is considering developing standards from the findings of the FHC against which we assess consultant and trainee behaviour.

Therefore, the RCP will take the following action.

Action	Timescale
> The RCP will incorporate the recommendations of the Francis Inquiry into the Future Hospital Commission ready for publication in 12 September 2013.	By September 2013

The government's response to Francis so far

Chief inspector of hospitals and hospital rating

The RCP has significant concerns with the proposed hospital rating system. The RCP does not believe that a single score for a care provider is the best way forward. It will only provide an average score of variable performance, and would therefore be meaningless for patients accessing a high or low performing service. The RCP believes that hospitals are too complex to have one meaningful rating. Instead, we suggest that aggregate scores over each of the domains of quality would be a more effective and useful alternative to a single summary score for each provider.

The role of chief inspector has potential to show leadership within the CQC to quality improvement in hospitals, but must be able to act with real teeth if patient safety issues are identified.

Duty of candour

The RCP supports the principles of a duty of candour, which doctors already have as part of the requirements of their registration with the GMC. The RCP recommends that patients and/or carers should receive an explanation or an apology early on in the complaints process, which would help to avoid litigation in most clinical negligence cases that involve smaller injuries. In fact, the RCP recommends there being two patients and an elected doctor on trust boards, who are responsible for ensuring that the board are aware of, and address, concerns.

The RCP is working with the government and other relevant stakeholders on the development and implementation of the duty of candour policy.

Therefore, the RCP will take the following actions.

Action	Timescale
> The RCP will work with Care Quality Commission to develop a meaningful and effective system to inspect and rate hospital services.	Ongoing
> The RCP will continue to work with the government and other relevant stakeholders on the development and implementation of the duty of candour policy.	Ongoing

**‘What is required now is
a real change in culture,
a refocusing and
recommitment of all
who work in the NHS
– from top to bottom
of the system – on
putting the patient first.’**

Robert Francis QC, 6 Feb 2013

References

- 1 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Chaired by Robert Francis QC. London: Stationery Office, 2013.
- 2 Royal College of Physicians. *Royal College of Physicians’ response to the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: RCP, 2013.
- 3 Medical Schools Council. *The Consensus statement on the role of the doctor*. London: Medical Schools Council, 2009.
- 4 Royal College of Physicians. *Doctors in society*. London: RCP, 2005. www.rcplondon.ac.uk/publications/doctors-society [Accessed 22 July 2013].
- 5 Royal College of Physicians. *Future Physician*. London: RCP, 2010. www.rcplondon.ac.uk/publications/future-physician [Accessed 22 July 2013].
- 6 Joint Royal College of Physicians Training Board. www.jrcptb.org.uk/Pages/homepage.aspx
- 7 The Faculty of Medical Leadership and Management. *Medical leadership competency framework*, 3rd edition. London: FMLM, 2010.
- 8 Faculty of Medical Leadership and Management. www.fmlm.ac.uk
- 9 National Clinical Guidance Centre. www.ncgc.ac.uk
- 10 National Clinical Guidance Centre. *Patient experience (Guidance and Quality Standard)*. London: NCGC, 2012.
- 11 Royal College of Physicians. Clinical audits. www.rcplondon.ac.uk/resources/clinical-resources/clinical-audits
- 12 Royal College of Physicians Strategy for Quality. www.rcplondon.ac.uk/policy/improving-healthcare/rcp-strategy-quality
- 13 National Quality Board. *Quality governance in the NHS – a guide for provider boards*. London: National Quality Board, 2010.
- 14 The quality mark for elder-friendly hospital wards. www.rcpsych.ac.uk/PDF/QM%20leaflet%202013HR.pdf [Accessed 22 July 2013].
- 15 Royal College of Physicians. *Standards for the clinical structure and content of patient records*. London: RCP, 2013.
- 16 www.rcplondon.ac.uk/projects/clinical-commissioning-hub
- 17 Royal College of Physicians. *Consultant physicians working with patients – revised 5th edition*. London: RCP, 2012. www.rcplondon.ac.uk/resources/consultant-physicians-working-patients-0
- 18 Royal College of Physicians. Invited service reviews. www.rcplondon.ac.uk/resources/clinical-resources/invited-service-reviews
- 19 *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005 – March 2009*. Chaired by Robert Francis QC. London: Stationery Office, 2010.
- 20 Overview of the quality mark for elder-friendly hospital wards. www.rcpsych.ac.uk/quality/qualityandaccreditation/elder-friendlyqualitymark/overviewofthequalitymark.aspx
- 21 Shape of Training. www.shapeoftraining.co.uk
- 22 RCP response to the Shape of Training review consultation. www.rcplondon.ac.uk/resources/rcp-response-shape-training-review-consultation
- 23 Royal College of Physicians. Patients deserve better out of hours care says RCP president. www.rcplondon.ac.uk/press-releases/patients-deserve-better-out-hours-care-says-rcp-president-0
- 24 Royal College of Physicians. *Acute care toolkit 4: delivering a 12-hour, 7-day consultant presence on the acute medical unit*. London: RCP, 2012.
- 25 Royal College of Physicians. *Hospitals on the edge? The time for action*. London: RCP, 2012.
- 26 NHS Confederation. www.nhsconfed.org/Pages/home.aspx
- 27 The Society for Acute Medicine. www.acutemedicine.org.uk
- 28 The College of Emergency Medicine. www.collemergencymed.ac.uk
- 29 Royal College of Physicians. *Urgent and emergency care: a prescription for the future*. London: RCP, 2013. www.rcplondon.ac.uk/resources/urgent-and-emergency-care-prescription-future
- 30 Future Hospital Commission. www.rcplondon.ac.uk/projects/future-hospital-commission

Royal College of Physicians
11 St Andrews Place
Regent’s Park
London NW1 4LE

www.rcplondon.ac.uk



**Royal College
of Physicians**



Setting higher standards