# One year since Francis

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The conclusions of the public inquiry into Stafford Hospital last February have loomed large over a year of intense focus on quality of care in the English NHS. Robert Francis QC's report famously included no less than 290 recommendations, providing the backdrop to a flurry of Government and policy responses. It also delivered his final judgement on why the failings in Mid Staffordshire had gone unnoticed and unchallenged by those whose job it was to notice and act on them – including front line staff, the board of the hospital, commissioners, regulators, and the Department of Health.

The Nuffield Trust's **new report (http://www.nuffieldtrust.org.uk/publications/francis-inquiry-one-year-on)** , one year on, aimed to make an assessment of the impact the inquiry, and everything which went with it, has had inside England's acute hospital trusts. Through interviews with 48 members of staff in five case study trusts, and an online survey sent to all acute trusts, we took a snapshot of how hospitals have responded to the report.

It was clear from our survey (to which 53 trusts responded) that at the highest levels of trust leadership, the report has been taken very seriously and seen as a prompt for action. 100% of trusts reported that they had discussed it at a board meeting. 82% reported that it had led directly to new action or initiatives.

The case study interviews added more detail to this picture. While the report was a milestone for acute trusts, its impact was inseparably linked to the full story of Stafford Hospital which came before it (including the **first Francis Inquiry (http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018)** in 2010 into the events at Stafford), the **Government response (https://www.gov.uk/government/news/francis-report-on-mid-staffs-government-accepts-recommendations)** in November 2013 to the public inquiry, and other reviews which came after the public inquiry, including the **Keogh review (http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx)** of hospitals with high standardised mortality rates, and Don Berwick's examination of the NHS culture of quality and safety.

Many leaders remembered a moment of shock during the two Francis inquiries as they realised the depth of the failure which senior figures at Mid Staffordshire had failed to identify. A clear priority, especially for boards, was often to ask how they could be certain that nothing comparable was happening at their trusts. As a result, boards reported spending far more of their time on quality issues than had been the case in previous years. One Chief Executive expressed the shift in priorities by telling us that "the big thing it seems to me that Francis has changed… is that I'd rather be hung for money than for quality and safety."

As a result several trusts had developed new standards of care which could be compared across time and wards to define and detect unacceptable performance.. These often focused on staffing levels, and clinical indicators of poor care such as falls and pressure ulcers. Some respondents reported new forms of peer review, such as holding mock CQC inspections and internal "Keogh reviews" with assessment by commissioners and external clinicians.

Another focus for change mentioned by senior leaders in our study was using patient complaints and concerns raised by staff as a positive tool for improvement. Many trusts were working to reform their complaints systems to rectify long backlogs of complaints, the slow speed at which complaints often made their way up the hierarchy, and unnecessary duplication of processes.

Interviewees also described efforts to encourage staff to think about patient experience and be candid about their concerns, with "Francis roadshow" meetings and real-time incident reporting software among the initiatives introduced. Yet elements of a more closed culture which still hindered efforts to put a strong emphasis on quality were sometimes glimpsed. "I don't feel I can go to the chief executive and tell… my concerns, even though [they say] I can", one ward manager told us.

We cannot yet measure whether the undoubted commitment of hospital leaders to changing culture, using better indicators, and management systems to improve quality has had an impact on patient experience or safety. It is important to recognise that the cultural problems identified by Francis went far beyond any individual trust, and many interviewees felt that performance management by Monitor, commissioners, and the Trust Development Authority could at times still feel overbearing or apparently inconsistent. Some picked out the heavy emphasis on compliance with the four-hour accident and emergency target as unhelpful, as it was perceived as a process indicator that did not fully capture patient experience and clinical outcomes.

Many chief executives and clinical managers we spoke to felt that they were sometimes faced with difficult trade-offs between staffing levels sufficient to provide quality care, and the need to meet challenging targets for savings. While these perspectives from NHS hospitals on finance and regulation are only based on a modest sample of trusts, , what we heard should remind policy makers to keep an eye out for unintended consequences for quality, as they push to improve financial and other aspects of performance. As we move into a future where the NHS will find meeting performance and financial targets more challenging than ever, it is vital that we find ways to ensure that changes to culture and practices triggered by the Francis Inquiry develop fully, and remain embedded in the system.