

- 2 Davies SC. *Annual Report of the Chief Medical Officer, Volume Two, 2011, Infections and the rise of antimicrobial resistance*. London: DoH, 2013. www.gov.uk/government/uploads/system/uploads/attachment_data/file/138331/CMO_Annual_Report_Volume_2_2011.pdf [Accessed 5 April 2013].
- 3 Innovative Medicines Initiative. Combact. Combatting Bacterial Resistance in Europe, 2013. www.imi.europa.eu/content/combacte [5 April 2013].
- 4 Payne D, O'Brien S. *Combating Antibiotic Resistance: New Drugs 4 Bad Bugs (ND4BB)*. IMI Stakeholder Forum 2012. www.imi.europa.eu/sites/default/files/uploads/documents/SF2012/WkshpA_ppt2_Payne.pdf [Accessed 5 April 2013].
- 5 IMI Translocation. Molecular basis of the bacterial cell wall permeability, 2013. www.imi.europa.eu/content/translocation_ [Accessed 5 April 2013].
- 6 Medical Research Council. IIB Programme, 2013. www.mrc.ac.uk/Ourresearch/Boardpanelsgroups/IIB/Programme/index.htm#P46_3438 [Accessed 5 April 2013].

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■ EDITORIALS

Clinical Medicine 2013, Vol 13, No 3: 220–1

Francis inquiry: effecting change

Richard Thompson

At last it has been published – the second report by Robert Francis QC of the Mid Staffordshire NHS Trust Public Inquiry – with 293 recommendations. None of them is unexpected; see the RCP's recent reports: *Hospitals on the edge*?¹ and *The medical registrar*,² and the upcoming *Future Hospital Commission*, which is shortly to report.

Officers of the RCP have visited Stafford hospital three times after the failings of the Trust first made the news. The physicians and nurses there were not evil, but they were frustrated and disempowered by a management striving to achieve impossible financial targets and become a Foundation Trust, and thus were deaf to cries for help from patients and staff. Standards fell, there was occasional brutal behaviour, corners were cut and statistics were manipulated.³ More generally, under the current perverse (not to say immoral) tariff system, many smaller hospitals, like Stafford, cannot generate enough income to afford to treat the steadily increasing tide of acutely ill elderly patients, 15% of whom are likely to be readmitted within 28 days. Hence many hospitals are not sustainable, squeezed between this unmanageable medical load and PFI payments. Reconfiguration may not help because the patients still have to be seen somewhere and will continue to cost more to treat than clinical commission groups (CCGs) will pay under the current tariff.

Francis emphasises the crumbling of the culture of care and generosity of purpose, which is being replaced everywhere by an atmosphere of fear. All patients should have a doctor responsible for them – and so where were we when patients were neglected, developed pressure ulcers or were allowed to starve or dehydrate? Was not a consultant in charge of each and every one of them and were not trainees daily on these wards?

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The inquiry rightly criticised nursing standards, but doctors must bear part of the blame for these poor standards, which are often only brought to light by determined relatives, rather than the staff.

Slogans will not motivate staff in the NHS, and so what practical changes can be made? We must agree with Francis that consultants and trainees should take responsibility, and probably accountability, for the whole care of their patients, not just focusing on their particular clinical area of expertise. This implies that there must be a return to the consultant-led team in charge of the clinical pathway and thus continuity of care. Clinicians must work more closely with the nursing teams to improve all those things we could tend to forget, such as nutrition, hydration, skin care, dignity and understanding; we must think of dementia. We are all now physicians for the care of the elderly and there is nothing wrong with that.

I believe there is failure of leadership for all the highly motivated, but deeply disillusioned, health professionals. Physicians must work together as leaders to change, as Francis underlined, the baleful financial culture in the NHS, which comes from the top where there seems little understanding of the increasing pressures on medical teams. This is highlighted by universal unhappiness among the key medical registrars.² To do this, senior doctors must meet regularly in committees with managers to discuss how to innovate and improve the working of their hospital, and interact directly with the Trust board. Remember that doctors working together are a powerful force. Trainees are the eyes and ears of the hospital and should also be consulted and listened to – read about the efforts of Basildon trainees to do this in the February 2013 issue of *Commentary*.³

The RCP's *Future Hospital Commission*, which will report to me later this year, will look at many of these issues. However, I believe that, in addition, an elected doctor or nurse should sit on the Trust board and be responsible for staff health and morale,

not the medical director, who has a different role and is appointed by management.

As Francis says, there should be a much more positive response to the raising of concerns, pejoratively termed 'whistle-blowing'. Concerns from all staff and patients should be welcome; they can be a force for good. I believe that a record of these concerns must be discussed in annual appraisals as a positive feature of revalidation. The appraiser should have to check with the appraisee that the concerns are reasonable and have been properly answered, and if not, help to follow them up. A lack of concerns raised in an appraisal should thus be seen as failure.

A consultant should be nominated in rotation to support a ward by regularly discussing concerns with the ward 'manager' and helping to resolve them. Experienced ward sisters leading a mixed nursing team should be paid as much as the director of nursing, for they are as important as doctors in maintaining high standards of care.

All nursing staff should, as Francis suggests, be appraised annually and, in particular, health care assistants should be regulated and given training. Indeed all health workers, including cleaners, porters and phlebotomists, should be trained to recognise dementia and other problems so that they can relay information to clinical staff and help and reassure patients. These NHS staff need to be valued.

The positive influence of patients should be harnessed by doctors and embedded in the management of Trusts. Patients know what they want, they see what is happening when doctors are not there, and they want to help, but are usually ignored, as at mid-Staffordshire NHS Trust. Their concerns are valuable and should reach the highest levels of management. Health professionals can help this happen. Perhaps two patients (but

not their representatives) should sit on Trust boards where they could oversee staff health and morale, quality checks and concerns. They are not the same as patient governors.

Finally, managers should spend time working in clinical areas during their training – I believe they should be grouped into a professional college or faculty, which would be responsible for standards, and they should probably be regulated. Fundamentally, their aim should be to make every meeting of a patient with a health professional as efficient as possible.

I am, however, sceptical of slogans, such as the proposed duty of candour, the NHS constitution, etc. It is, as Francis says, the culture that has to change from top to bottom. This will not happen, I fear, until health professionals are empowered to lead and effect change.

References

- 1 Royal College of Physicians. *Hospitals on the edge? The time for action*. London: RCP, 2012. www.rcplondon.ac.uk/projects/hospitals-edge-time-action [Accessed 8 April 2013].
- 2 Chaudhuri E, Mason NC, Logan S *et al* on behalf of the Royal College of Physicians. *The medical registrar. Empowering the unsung heroes of patient care*. London: RCP, 2013. www.rcplondon.ac.uk/sites/default/files/future-medical-registrar_1.pdf [Accessed 8 April 2013].
- 3 Dancy L, Steel L, Tand D. Right place right time. Letter from the 'coal face'. *Commentary* 2013;February 2013:32–3.
- 4 Mid Staffordshire Inquiry. Day 98 transcript, 2011. www.midstaffspublicinquiry.com/sites/default/files/transcripts/Monday_13_June_2011_-_transcript.pdf [Accessed 8 April 2013].

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