The Francis Report – Lessons For Havering

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Aims for today

• Key messages from the Francis Report
• What we have learned in Havering
• Action we have taken in Havering
• Next steps for Havering
Key messages from the Francis Report

What have we learned in Havering

Action we have taken in Havering

Next steps for Havering
PREFACE.

It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm. It is quite necessary, nevertheless, to lay down such a principle, because the actual mortality in hospitals, especially in those of large crowded cities, is very much higher than any calculation founded on the mortality of the same class of diseases among patients treated out of hospital would lead us to expect. The
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“What can’t be cured must be endured,” is the very worst and most dangerous maxim for a nurse which ever was made. Patience and resignation in her are but other words for carelessness or indifference—contemptible, if in regard to herself; culpable, if in regard to her sick.
Some figures......

• 1 million pages of documentary material
• 250 witnesses
• 139 days of oral hearings
• Terms of reference announced 9 June 10
• Report handed to SOS 5 February 13
• Costs £13 million to November 13
• 1781 pages
• 290 recommendations
Listening to those who matter
Warning signs

• Patient stories
• Complaints
• Staff concerns
• Staff reductions
• Whistleblowers
• Mortality/Serious Incidents
• Governance issues
• Finance
The daughter of a patient in ward 11

In the next room you could hear the buzzers sounding. After about 20 minutes you could hear the men shouting for the nurse, “Nurse, nurse”, and it just went on and on. And then very often it would be two people calling at the same time and then you would hear them crying, like shouting “Nurse” louder, and then you would hear them just crying, just sobbing, they would just sob and you just presumed that they had had to wet the bed. And then after they would sob, they seemed to then shout again for the nurse and then it would go quiet......
The daughter-in-law of a 96 year old patient

We got there about 10 o’clock and I could not believe my eyes. The door was wide open. There were people walking past. Mum was in bed with the cot sides up and she hadn’t got a stitch of clothing on. I mean, she would have been horrified. She was completely naked and if I said covered in faeces, she was. It was everywhere. It was in her hair, her eyes, her nails, her hands and all on the cot side, so she had obviously been trying to lift herself up or move about because the bed was covered and it was literally everywhere and it was dried. It would have been there a long time, wasn’t new.
She had got a cloth, like a J-cloth, and she cleaned the ledges and she went into the wards, she walked all round the ward with the same cloth, wiping everybody’s table and saying hello, wiping another table and saying hello. Came out of there, went into the toilets and lo and behold, she cleaned the toilets with the same cloth, and went off onto the next bay with the same cloth in her hand. You can’t believe what you saw, you really couldn’t believe what you saw.

A visiting relative in 2006
A patient death
Systemic failure of safety?

A detailed investigation has been undertaken including obtaining information from 14 members of staff and considering a substantial number of documents. The following problems have been identified:

- failure to control diabetes
- failure to administer prescribed drugs
- failure to undertake nursing handovers properly or at all
- failure to complete nursing records adequately or at all
- failure to conduct medical ward rounds properly
- failure to make adequate or proper notes of ward rounds and care plans
- failure to give the patient a diabetic menu
- failure to report this matter as a SUI in a timely fashion
- failure to report to the Coroner
Fear of trouble

• Some of them were so stroppy that you felt that if you did complain, that they could be spiteful to my Mum or they could ignore her a bit more.

• There would have been a lot of little incidents that just made you feel uncomfortable and made us feel that we didn’t want to approach the staff. I did feel intimidated a lot of the time just by certain ones.

• “you have rushed the blood through”, I said to the sister, and she said,….I have had to come in and give the blood and don’t moan…because I have had no break today. That’s what she said, and she probably hadn’t had a break. So I didn’t mention the frusemide to her because she was obviously fraught.
Complaints

Case 5

126. The patient was admitted to EAU on 27 May 2005 following a fall at home. The family visited on 29 May 2005 to find extensive bruising to the patient’s forehead, right-hand side of the head and a cut to the right eye. The family believed that the patient had fallen but there were no incident forms to determine whether or not a fall had occurred in the EAU or if the injuries related to the fall at home. The action plan in response, on 22 January 2007 (following referral of the complaint to the HCC), stated that upon admittance to the EAU all patients would be assessed for risk of falls and that all staff would be trained in a new falls policy (which included notifying relatives when a fall occurred).

Case 6

127. The patient was admitted to the EAU on 19 January 2007 and family attended on 20 January 2007 to be informed that patient had fallen out of bed and hit his head. The complaint was made on 9 July 2007 and response was completed on 10 February 2008, including a statement in the action plan saying that all staff in the EAU would be instructed to maintain effective communication after a patient had fallen.

Case 7

128. The patient had fallen out of bed in the EAU and the family had not been informed. A complaint was made on 4 September 2007 and the response was completed on 8 October 2007, including an action plan that stated staff were to inform relatives when falls had occurred, should complete an incident report and utilise FRASE.
Staff concerns – the wards

“I mean in some ways I feel ashamed because I have worked there and I can tell you that I have done my best, and sometimes you go home and you are really upset because you can’t say that you have done anything to help. You feel like you have not – although you have answered buzzers, you have provided the medical care but it never seemed to be enough. There was not enough staff to deal with the type of patient that you needed to deal with, to provide everything that a patient would need. You were doing – you were just skimming the surface and that is not how I was trained.”
Staff concerns – A&E

The nurses were so under-resourced they were working extra hours, they were desperately moving from place to place to try to give adequate care to patients. **If you are in that environment for long enough, what happens is you become immune to the sound of pain or you walk away.** You cannot feel people’s pain, you cannot continue to want to do the best you possibly can when the system says no to you, you can’t do your best.
Key messages from the Francis Report

What have we learned in Havering

Action we have taken in Havering

Next steps for Havering
Lesson 1 – The system’s business – not the patient

• GP’s
  – Must identify and look at concerns and pass them on

• Clinical Commissioning Groups
  – Equipped and fulfilling all duties to improve on quality of care – stronger quality assurance

• Scrutiny committees
  – To ask more questions and be provided with the expertise to triangulate data

• Patient and public groups
  – Need to be outward looking
  – Require sufficient support and expertise
Lesson 2 – close working with regulators

• National Trust Development Agency
  – Sharing information early – being open and transparent

• Monitor
  – Working to check on quality of delivery
  – Continue to focus on governance – change on emphasis though

• CQC
  – More sharing of information regularly and with more transparency
  – The sharing of patient stories and concerns
  – Would the CQC spot a Stafford today?
Lesson 3 – Professional groups thinking more of patients

- **Royal College of Nursing**
  - Utilise all professional support early
  - Work collaboratively to develop and implement quality standards

- **Nursing Midwifery Council/General Medical Council**
  - Wider view of patient safety
  - Implementation of professional regulation

- **Health Education England**
  - Direct input into training and education
  - Back to basic’s
  - Workforce development plans reflect needs and promote quality of care
Key messages from the Francis Report

What have we learned in Havering

**Action we have taken in Havering**

Next steps for Havering
Adopted recommendations

- Common values
- Fundamental standards
- Openness, transparency and candour
- Compassionate, caring, committed nursing
- Strong patient centered healthcare leadership
- Accurate, useful and relevant information
- Culture change collaboratively
Values – clarity and commitment

• Make NHS constitution the shared reference point for values

• All NHS and contractors to commit to NHS Values

• Put people first
  – Focus on staff putting patients before themselves
  – Staff do everything in their power to protect patients from avoidable harm
  – Openness and honesty with patients regardless of consequences for themselves
  – Apply the NHS values in all our work
Key messages from the Francis Report

What have we learned in Havering

Action we have taken in Havering

Next steps for Havering
Fundamental Standards

• Continue to implement the recommendations at pace

• What the public see as absolutely essential

• What the professions accept can be achieved

• Compliance measured by evidence based methods

• Policed by CQC

• Enhanced quality standards delivered through commissioning
Measuring Success

**Openness**: enabling concerns and complaints to be raised freely and fearlessly, and questions to be answered truthfully.

**Transparency**: making accurate and useful information about performance and outcomes available to staff, patients, public and regulators.

**Candour**: informing patients where they have or may have been avoidably harmed by healthcare service whether or not asked.