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A decade after Francis: is the NHS safer and more open?

Recurrent organisational catastrophes remain a disheartening reality

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It is 10 years since Robert Francis published the three volume report of the public inquiry into failings at Mid Staffordshire NHS Foundation Trust.[1] Few will need reminding of the harrowing accounts of care at Stafford Hospital or the inquiry's damning verdict—covering not just the trust but system failures at multiple levels. The government's response to the inquiry, to the advisory group appointed to identify high level actions, and to other contemporaneous investigations, signalled a determination for change. It promised wide ranging interventions and legal and regulatory reforms to tackle problems of culture, openness, and willingness to learn.[2 3] What is the legacy for the safety of patients in England?

The policy response sought to act on many of Francis's recommendations. The statutory duty of candour on provider organisations when patients are harmed was implemented quickly, as was the requirement that providers appoint a "freedom to speak up" guardian to promote openness and ensure people's concerns are heard. The Care Quality Commission's (CQC) approach to inspection was reformed. Frameworks for responding to patient safety incidents have undergone two major shifts, while the Healthcare Safety Investigation Branch was introduced, then expanded, then restructured.

Other Francis recommendations were not followed by policy changes. For example, despite growing evidence,[4] standards on minimum staffing ratios have not been realised—and long term financial and workforce challenges, together with post-pandemic pressures on services, have made safe staffing increasingly politically contentious.

Evaluations of the changes introduced are rare, and where they have been carried out—for example, on openness interventions in trusts—they suggest that organisational commitment and capability has varied.[5] The effect of system interventions is similarly difficult to gauge. More broadly, the complex nature of the policy response to the Francis reports and the confounding effects of the pandemic and other variables make it difficult to assess progress. For example, changes to the CQC's approach do not seem to have had an effect on organisational improvement.[6]

Some evidence exists for aggregate improvement across the healthcare system as a whole, whether or not driven by the policy response. The proportion of provider organisations rated good or outstanding for safety by the CQC has risen since 2014, and staff seem more confident about speaking up about concerns.[7] But not all the signs are positive. Service users report a stagnating or worsening picture of openness in community mental health services.[8] The proportion of staff indicating problems around openness remains worrying: two fifths are not confident they will be treated fairly if they report concerns.[7] Patient satisfaction is falling,[7] mirrored by declines in indicators of staff wellbeing and morale, and in staff views on their organisations' responsiveness to safety issues.[9]

The intersection of safety problems with socio-structural inequalities has proved particularly stubborn: staff from racially minoritised backgrounds continue to experience disproportionate challenges in getting their voices heard,[10] and marginalised patient groups remain at high, and possibly worsening, risk of excess morbidity and mortality.[11]

Among the most disheartening features of the post-Francis NHS are recurrent organisational catastrophes. Three aspects of this phenomenon are especially sobering. First is the repeated failure to identify promptly and intervene effectively in the worst of these events, linked to a persistent lack of valid and reliable measures for surveillance, early warning, and risk based regulation.[12] Second is the NHS's ongoing difficulty in tackling problems of culture and behaviour, including the malign influence of individuals whose unacceptable behaviour and conduct create toxic working environments.[13] Third, and perhaps most dispiriting of all, is the disproportionate representation of vulnerable groups in these disasters, including maternity service users and infants, and people with learning disabilities. Failure to listen to the voices of patients and carers is a recurrent theme of investigations into avoidable harm—and one that the system seems incapable of heeding.

Achieving and sustaining improvement

What can the NHS do to realise improvement and reduce the likelihood of further tragic events? Sustainable improvement is likely to rest more on achieving the spirit than the letter of Francis's recommendations. We suggest three overarching priorities.

These need to start with listening. Psychological safety—a sense among staff and patients that it is safe to speak up without fear of retaliation or being undermined—is critical. But organisations that fail to hear and act will repeat their mistakes and suppressimportant sources of insight.[14]

Next, therefore, is learning: gathering, collating, and acting on intelligence, quantitative and qualitative, formal and informal, leading and lagging. Investment in systems, processes, and people is central, including taking advantage of new technologies.[15] And there must be an end to the repeated failure to evaluate initiatives and learn from them.

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Finally, strong leadership is essential. Making patients "the first and foremost consideration of the system and everyone who works in it"[1] means committing to evidence based improvement. It means an uncompromising focus onaddressingcultural and behavioural problems. And it means attending to everyday issues—from operational failures in information systems, through administrative inefficiencies, to consistently demonstrating respect for patients and care for staff—that are central to making openness and safety part of the organisational fabric.

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