"I get worried that whenever something goes wrong we blame the regulator"

Bruce Keogh, medical director of NHS England

"People have been complacent and said, well, that's normal for the NHS"

Sam Barrell, chief of the clinical commissioning group in Torbay and a general practitioner

"There was a level of disengagement and disempowerment which you saw at Mid Staffs which you can see throughout the whole healthcare system"

Niall Dickson, chief executive, GMC

"Can we please have an open and honest dialogue with the public about what can and can't be done"

Robert Francis, QC and chairman of the Mid Staffordshire NHS Foundation Trust Public Inquiry

"We would need to change our mindset about what the state of quality is inside NHS hospitals"

Ruth Thorlby, senior fellow in health policy at the Nuffield Trust

"If I were in the department, the question I'd pose would be, what can I abolish?"

Stephen Dorrell, chair of the health select committee and former secretary of state for health

After Francis, what next for the NHS?

After the landmark Francis report into what went wrong at Mid Staffordshire NHS Foundation Trust, a panel of experts gathered at a *BMJ* round table discussion held during the Nuffield Trust 2013 health policy summit last month to discuss how the report's recommendations could change the NHS. **Adrian O'Dowd** reports

What are the main points that people should take away from Robert Francis's report into Mid Staffs? That was the question with which *BMJ* editor in chief Fiona Godlee, chairing the session, began discussions with the panel of experts, whom she said were there to help consider what was likely to and should happen to the NHS after Francis.

Julie Moore, chief executive of University Hospital Birmingham and chair of the Shelford Group, made up of leading academic teaching hospitals, said: "I think one of the things that the Francis report pointed to is how many people are currently involved in monitoring, overseeing, and regulating quality—and I think one of the key points was to simplify that."

Bruce Keogh, medical director of NHS England, formerly the NHS Commissioning Board, said quality should start within an organisation itself, adding: "We've got an NHS that employs 1.4 million people, and each and every one of those people has a contribution to make.

"Every professional that has to deal with patients sets the tone for quality of that organisation, and the role of the organisation is to set an environment which encourages appropriate behaviour in that encounter and supports it.

"Frankly, if that worked, you wouldn't need a regulator for quality. It would be ingrained in the system. I get worried that whenever something goes wrong we blame the regulator. The blame is placed very high up in the system when actually the problems are deep in an organisation if there are issues of quality. They are often simply down to a tiny handful of individuals who cast a long shadow over that organisation."

Sam Barrell, chief executive officer of the clinical commissioning group in Torbay and a general practitioner, said the main point she took from the Francis report was that listening to patients mattered: "I think there has been a danger in the past where people have said things and people have been complacent and said, well, that's normal for the NHS. I think it has almost normalised patient complaints to saying they don't count as much as they should.

"There has also been a problem where our GPs have stopped putting in alerts and concerns about services over a period of years when they have seen things happen that aren't right for patients because they've felt a frustration about nothing changing and nothing being improved.

"So what is really important moving forward is that we create systems where we can collect trends in complaints, we can listen to the patient, engage them throughout the commissioning cycle properly, and make sure that when people raise concerns there is a systematic system so they get proper feedback."

A failure to listen was one of the key lessons from the Stafford scandal, argued Jeremy Taylor, chief executive of National Voices, a coalition of health and social care charities, who said: "For me the takeaway message is we need to do something to strengthen the patient voice in all its guises, each individual patient feeling that they can speak up and raise concerns, which we know often doesn't happen, either because of low expectations that anything will happen as a consequence of raising concerns or fear of what might happen if they raise a concern."

Quality in foundation and non-foundation trusts

As chief executive of a foundation trust—Great Ormond Street Hospital—Jan Filochowski said the report boiled down to the culture and behaviour of NHS organisations and staff.

"I was very struck by a coroner commenting on an unwarranted death in a large teaching hospital a year or so ago," he said. "He died of thirst because he needed to be given water and this was ignored, and the coroner described the culture that allowed that to happen as a culture of assumption. That struck me. We must never assume we know. We must always check and find out.

"We got caught out by the change in the type of patients that we now deal with"

Nigel Edwards, senior fellow at the King's Fund and director of Global Healthcare at KPMG

"It is about time we talked about the good things that go on and stopped trying to vilify absolutely everybody"

Julie Moore, chief executive of University Hospital Birmingham and chair of the Shelford Group

"There is a need to take the patient voice more seriously and institutionalise ways of doing that"

Simon Stevens, president of global health at United Health, the United States insurer

"Why do we distinguish between foundation trusts and non-foundation trusts?"

Jan Filochowski, chief executive of Great Ormond Street Hospital

"People at all levels will take Robert's report and use it as a way to fight bureaucracy"

Alistair McLellan, editor of *Health Service Journal*

"Candour isn't just about the law. It's also about practice, so everybody has got a responsibility there"

Jeremy Taylor, chief executive of National Voices, a national alliance of health and care charities in England

"One of the things it has made me think is why do we distinguish between foundation trusts and non-foundation trusts? Our duty is the same. Shouldn't our regime for quality, for safety, for checking them be the same?"

Stephen Dorrell, former health secretary and current chair of the parliamentary health select committee, said discussions after big reports were published often led to "sound bites" that crystallised thinking.

"The example I often quote from the Bristol report into much smaller scale but very similar examples of failure in Bristol over 20 years ago, was that the real scandal of Bristol was not that nobody knew, it was that everybody knew," he said.

"The takeaway out of Robert's report for me was the phrase that people were doing the system's business. They weren't focusing on the patient in front of them. It's that sense of paranoia about how things can go wrong, understanding that it isn't somebody else's problem. It's your problem if you see something going as it shouldn't—something going wrong around you."

GMC chief executive Niall Dickson said he was still unsure whether the Francis report would prove to be a "seminal moment."

"Are we going to look back in 10 years' time and say that this thing has actually made a difference or not? I'm still unclear about that," he said.

"On one side, there is an issue around the role of national regulation, both system and professional and how that works, and not overestimating what it can do, but on the other hand making sure it is considerably better joined up than it has been.

"On the other side, I think down at the level of the individual patient and professional—how those professionals feel about themselves when they go to work in the morning—that's about organisational leadership and good management and all the rest of it, but it's also about the professions themselves recognising their responsibilities.

"There was a level of disengagement and disempowerment which you saw at Mid Staffs which you can see throughout the whole healthcare system. If that continues, none of the other things will work."

Patient and staff voices

Listening to patients and staff more closely was crucial as a lesson to learn from events at Mid Staffs, said Simon Stevens, president of global health at US insurance company United Health and a key adviser to the prime minister during the health reforms of Tony Blair's government.

"One of the fundamental lessons I think that comes out of Robert's report is that there is a need to take the patient voice more seriously and institutionalise ways of doing that. But I also think there are early warning signals that we get from the nurses, the staff of individual hospitals.

"The fact is that the response to the Bristol Royal Infirmary report in parliament in 2002 said that clinical outcomes data would be published, and it is now 2013 and we are still saying that it is going to be published sometime this year. So if we were serious about that, we wouldn't have let that slide for 11 years."

Everyone involved in the NHS had to change their mindset, argued Ruth Thorlby, senior fellow in health policy at the Nuffield Trust, who said: "One of the main messages that I've got out of the report is the implication that we would need to change our mindset about what the state of quality is inside NHS hospitals from being, 'let's assume it's mostly good with some bad bits' to saying, 'it probably might be quite bad and let's prove to us that it's good.'"

Health Service Journal editor Alistair McLellan said many people would make the mistake of overestimating the short term impact of the Francis report while also underestimating its long term impact.

"However, out there in the system I think that there are a number of people at all levels who will take Robert's report and use it as a way to fight their way through whatever bureaucracy they have to do to make the kind of changes that he talks about."

bmj.com More *BMJ* articles about the Francis report are at bmj.com/about-bmj/article-clusters/mid-staffs
bmj.com/podcasts Listen to a podcast on how to implement the Francis report's recommendations at http://bit.ly/14YZWVJ

Action needed now

Godlee then asked the panel what action they thought people wanted to see taken by the government, whose official response to the Francis report was published last week. The author of the report, Robert Francis, QC, said: "I think almost more important than that is how government behaves. By all means please implement all my recommendations, but can we please have an open and honest dialogue with the public about what can and can't be done.

"A lot, I think, will fall into Bruce's organisation's [NHS England's] camp in terms of openness and honesty about what we can pay for and not. We've got to be able to pay for the basic standards all the time, but with that may come a need for honesty about what that actually means in terms of other resources—things you can't resource."

Dorrell added: "If I were in the department, the question I'd pose would be, what can I abolish? What can I remove from the system in order to make the remaining bits of the system better?"

Asked what she would abolish, Moore replied: "We actually create organisations for a very good purpose, but when we then create another one that also does the same purpose, we still leave the other one in place. So there are at the moment locally five organisations whose remit is to advise on reconfiguration of services. I think that kind of thing has just got to stop."

Taylor talked about the plan to implement a statutory duty of candour. "Candour isn't just about the law. It's also about practice, so everybody has got a responsibility there. I think it could actually empower Bruce [Keogh] to do what Simon [Stevens] has been saying needs to happen but has taken 13 years.

"There needs to be much more focus on understanding and measuring, capturing the patient experience, which is still far too patchy."

Some things could be done now if everyone involved in the NHS started thinking about new ways of doing things, said Keogh.

"There are big organisational issues and structural things that can be changed, but for everybody in the workforce every day we need to be thinking about the appropriateness of care, about the elimination of overuse of treatments, and the transference of that to the underuse of treatments so that we get more appropriate care—and that will provide better care for greater taxpayers' value," he said.

Frontline staff

It was more useful to think of what frontline staff could do, according to Nigel Edwards, a senior fellow at think tank the King's Fund and director of Global Healthcare at KPMG: "Your question was what should the government do. I think it's the wrong question here because one of the things I take away from the story of Mid Staffs and from Robert's report is the importance of the frontline professional and their role.

"I think we need more understanding of what those organisations aren't doing that have done wrong. There is a real problem which isn't talked about much—about how hard it is being a frontline member, how much anxiety this produces, how difficult it is, how much support people require to do it well.

"The sort of thing that I think comes out from Robert's report is we got caught out by the change in the type of patients that we now deal with. It sort of crept up on us gently. We knew it was happening, but there are now a large number of people with dementia and with multimorbidity. We've got hospitals organised on the disciplines of medicine for dealing with acute care and, largely, patients who resolutely fail to fit in to the way that we've organised our services."

Thorlby cautioned that the last thing the NHS needed was a "blizzard of new standards" imposed on it, but added: "I just wonder, picking up on this question of how you understand what has happened to the frail elderly patient, could we define a set of standards that relate to the care of older people in hospital, those who are most at risk?

"It also raises the question of how we understand what is actually happening to older people in hospital because it was very striking reading through some of the witness statements that there are patients on the ward who had no one to advocate for them and possibly couldn't even speak very well."

Barrell said clinical commissioning groups should not wait for directives from the national commissioning board or government.

"We're already going through it [the Francis report] systematically, looking how we can embed it through our whole commissioning organisation, not just in our quality team, and using our audit committee to make sure that our action plan that we're going to develop around it is actually undertaken correctly."

Redesigning services

The imperative to redesign services was difficult to ignore, argued Stevens: "The question is everybody recognises that in principle there needs to be service redesign for frail elderly people with multiple chronic conditions, but is there much sign that that is actually happening in the system, or are we using a combination of salami slicing through reductions in the hospital tariff payment and the national pay squeeze as the principal route for taking efficiencies out?

"What is it that is actually going to lead to that service redesign? If you think about the big shifts that have happened in the patterns of care and the history of the NHS, they've often had a medical technology trigger.

"The NHS has been closing beds since the day it was founded, but that has been driven by things like penicillin for tuberculosis, the antipsychotics in the 1950s for the long stay psychiatric hospitals, the short acting analgesics for the move to day surgery. What is the equivalent technology trigger? Or is it just willpower that is going to lead us to redesign these services around the needs of frail elderly people?"

Next generation NHS

Godlee went on to ask the panel about where the next generation of committed and skilful managers and senior doctors and nurses was going to come from.

Moore said: "I don't know where they are going to come from because at the moment it doesn't seem like a very attractive job. In speaking to some young graduates from a business school recently, out of a class of 35, I asked who would consider a career in health. Not one hand went up. We discussed it—it was the news reports, it was the pressure, it was the perceived 'off with their heads' all the time.

"Now, I believe we should hold managers to account, but actually it is about time we talked about the good things that go on and stopped trying to vilify absolutely everybody. I believe 99.9% of doctors, nurses, and every other healthcare professional come to work to do a really good job. It's a vocation."

Francis was invited to make a final comment after the discussions, addressed to doctors.

"What doctors and indeed nurses and all other frontline staff have to deal with is the needs of the patient here and now, which is the most important thing. They can't stand away and say, 'Oh, the care pathways need to change' or 'The regulator is not doing its job.' They have a responsibility, and it should be a privilege to step forward and use their clinical autonomy to do the best for their patients."

Adrian O'Dowd, freelance journalist, Kent, UK
adrianodowd@aol.com

Competing interests: None declared.

Provenance and peer review: Commissioned; not externally peer reviewed.

Cite this as: *BMJ* 2013;346:f2074

EDITORIAL, p 7