Post-Francis Report: progress or stagnation?
A carer’s response

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Introduction
The Francis Report by the Mid Staffordshire Foundation NHS Trust Public Inquiry (“Mid Staffs”) was released in February 2013. What progress has there been implementing any of the recommendations? Has the Report become yet another source of reference for future inquiries? Has anything changed or is it changing?

It is worth taking an end of year assessment of two major themes from the Report: “putting the patient first” and “changing the culture”

Putting the patient first: what do we learn from the Francis Report?
This is always linked with listening to the patient and their patient representative groups.

In order to achieve Foundation status various authorities and agencies scrutinised the Mid-Staffs Trust. This included checking its compliance with the then applicable standards regulated by the Healthcare Commission (HCC). Local scrutiny committees and public involvement groups detected no systemic failings. Despite the scrutiny, the Francis Report indicated that the truth was uncovered in part by mortality rates and a group of patients and those close to them. The Report commented: “local GPs only expressed substantive concern about the quality of care at the Trust after the announcement of the HCC investigation, when it became obvious there were issues and when they were specifically asked”.

Too little too late seems appropriate response to these examples at Mid Staffs. The systems and procedures in place were clearly ineffective. Accompanying this was the uncomfortable realisation that similar situations were mirrored elsewhere in the NHS.

There is evidence that some effort is being made on the theme “putting patients first”, but how much is due to the Report is another matter.

The Old Age Faculty of the Royal College of Psychiatrists is producing a response to the Francis Report. My local Crawley Clinical Commissioning Group (CCG) is holding Board Meetings open to the public allowing questions from them, thereby displaying the spirit of
transparency. The CCG is also holding open meetings explaining how the delivery of medical care for certain medical conditions will be delivered in a more integrated manner. For example having entered the system, if further tests, scans, physiotherapy, or referral to another specialist is required, then that will happen automatically without the patient going to the bottom of the new specialist’s waiting list etc. But is it happening now?¹

But the problems are not confined to NHS hospitals. In July 2013 Oakhurst Grange, a BUPA nursing home in Crawley, closed because of “fears for the safety of residents”. My wife had Alzheimer’s and was a resident there from 2002 to 2008.

At Orchid View, another local care home, it was widely reported in the news that Penelope Schofield, the West Sussex coroner, on 18 October 2013, ruled that neglect led to the deaths of five residents. Schofield commented “those involved in the neglect at the home should be ashamed” and “There was institutionalised abuse throughout the home which started at an early stage. This was from the top down. It was completely mismanaged and understaffed and failed to provide a safe environment for residents.” I had attended a pre-opening viewing of Orchid View, a new purpose built Southern Cross care home in 2009. The home closed in 2011. The reason given was because Southern Cross ceased trading because of debts. This was true, but I knew some of the staff and was not surprised at the revelations at the inquest, shameful as it is.

Changing the culture
This is very much harder. No matter how logical, or how good their intentions, systems and procedures do not always work or deliver according to plan. All systems, procedures, standards, Codes of Practice or inspections rely on human beings to operate them. Should staff have to be told they need to be polite, gentle and considerate to patients especially the old and frail? Putting food out for sick frail patients clearly unable to feed themselves, rather than helping them or feeding them, is beyond belief yet it frequently happens.

Psychiatrists can do their bit and no doubt in many ways often have. But the patient is affected by total care which is not wholly dependent on doctors. It includes nurses and other staff, managers (non-medical), politicians, accountants, businesses and the public.

¹ e.g. see http://www.crawleyccg.nhs.uk/website/X05213/files/MSK_presentation_v_3_PV_pptx.pdf
Situations to be addressed

In determining post-Francis Report progress it is worth applying it to different situations. For example, how would it address the events Orchid View care home?

The home was reopened in August 2012 by Care UK and re-named Francis Court. The area manager for Orchid View, criticised by the coroner, became Care UK’s Regional Director and was placed in charge of the home (*The Argus* 22 October 2013), although later reports suggests that person has since been suspended. It is difficult to justify Care UK’s employment strategy. By comparison, Liz Martin, the administrator at Orchid View and the whistleblower, has not worked for the past 2 years. That seems incomparably unfair.

A lot of people need to examine their conscience over this, including the GPs. Whilst GPs are perhaps not to blame, and certainly not solely to blame, they and the CCG should reflect on whether they could or should have done more to improve the care at the home. The public also do not escape responsibility. At Oakhurst Grange, at times, relatives and the public refused to accept there were any faults.

In both of these homes staff were caring for residents with dementia, a challenging job. There were staff shortages, a problem in many homes and hospitals, but one which puts particular burden on staff. Some of the carers in Oakhurst Grange nursing home were very good. One particular carer, who was excellent with my wife, left to work in the local hospital as an HCA on a general non-mental ward. For patients with dementia the nurses ask her “how does she do it” as used to happen in the nursing home.

Some experiences of care home staff

These comments were made by carers in a study, started locally, some of whom had worked in the field for up to 25 years.

“Carers are often punched and even bitten; my hair has been pulled many a time over the years. I heard one resident say she “didn’t want that darkie coming into her room at all”. This can become a major problem for a carer who is not white”.

“Residents with dementia need to be treated very carefully – softly, softly approach is needed to calm an agitated resident down – good eye contact with them should be given”.
“A bit of empathy and understanding is also needed as these residents were once independent people running their own homes – now forced to live with other people in unfamiliar surroundings. This must be hard because sometimes these residents do have lucid moments. At the end of the day a carer needs to be compassionate. I have witnessed some carers to be the opposite on more than one occasion”.

“The main difficulty with aspects of personal care is time; one thing that carers have got little of”.

**Good experiences of other staff**

“I once worked with a Nigerian Prince who had been sent to England to finish being educated and to experience life at different levels. This included working nights at the nursing home. I found him to be a most humble and gentle man. He had extremely good people skills”.

“On duty one night I could not get my colleague to do the 2am pad round and complained to the Indian nurse on duty. He was another lovely man he offered to do the work with me although I pointed out it was not actually his duty to do her work he said he did not mind and was happy to help”.

“A Zimbabwean nurse who always made time for the residents. Through the night she would do an extra round and was often found in the kitchen making a cup of tea to take up to a resident. She would also help with duties in the home to help other carers”.

“I remember there was a resident who was very poorly and had to remain in bed for a long time. One of the nurses used to make sure he was always clean shaven after she had finished her duties of an evening because often the day staff would say they were too busy. He used to look forward to his wet shave, it seemed to me that as he was in his bed certain members of staff did not think that the shave was as important but he had always been a man that was clean, neat and tidy”.

“At one home the staff on night duty got on really well. It was a joy to go to work and the RGN on duty did not mind what work she got involved in. She gained an awful lot of respect from us who worked alongside her. The other carers on duty also had very high standards and we were confident the residents were well looked after on our nights”.


“A young carer who always paid particular attention on a morning to pamper any of the residents who were to get up making sure clothes coordinated, hair was combed and brushed and false teeth were rinsed out and given”.

**Bad Care by other staff**
“Resident was pushed over like a piece of meat when being changed, the carer was very rough”.

“Shouted at by nurse to stand and use the urine bottle rather than in the bed. Poor man could not weight bear properly so yanked him up by his arm so hard he cried out in pain. This was witnessed by 2 other members of staff. She lost her job over this”.

“A man was dying of cancer. He did not want what was on the menu he wanted ice cream. My employer said if he did not have what was on the menu then he would not get anything; he did not live much longer”.

**Carers and HCAs needing the Francis Report treatment**
In hospitals nurses are frequently mentioned, Healthcare Assistants (HCAs) rarely. Yet the HCAs provide the hands on care and no doubt often are seen by the public as “the nurse”. HCAs are frequently underrated, undervalued and hardly ever mentioned. This probably has something to do with the change of title from Nursing Assistant or Auxiliary to Health Care Assistant, a title which has no meaning on the actual job they do; doctors, consultants, managers and nurses are all “healthcare assistants” for a patient.

On this question a carer recounted:
“The title of carers is one issue that has bothered me for years and has made me annoyed with the title of carer.
When I first joined the care sector (over 25 years ago) I was very proud to be given the title of nursing auxiliary. I was trained by a wonderful Canadian nurse who really inspired me. I wore a nurse’s uniform but of course not the belt. I was passionate about my work and was eager to learn.
This title of nursing auxiliary however got taken away along with many other changes to the care sector and in some way has disintegrated the status of my worthwhile job.
I am sure this has affected the way my job is now paid because I feel the job has become undervalued. To reinstate my old title would certainly boost morale and make carers feel that they did indeed matter as part of
the workforce. After all it is the carers that get up to the residents close and personal”.

**Which of the following are true?**

- Doctors/GPs are conscientious frequently put their patients first
- Doctors/GPs are inconsiderate, often rude wrong and do not listen to patients
- Consultants can be relied upon
- Consultants are often the worst
- Patients are polite, considerate and only seek information and reassurance
- Patients are thoughtless, self-centred, demanding and a problem

Of course all are true. To that list can be added nurses and care workers. They all need to be considered to “put patients first” and “changing the culture”.

**Suggestions to “put patients first” and “change the culture”**

The following suggestions might help. They all interact.

1. Be receptive and responsive to enquiries or questions by patients or their family carers and not on the defensive every time.
2. Follow the Mental Capacity Act: act in the best interests of the patient. Getting that drink of water, help with eating that meal or being made clean should take priority over the financial best interests of the healthcare company.
3. Parity of esteem and value should apply to all staff providing health care. Doctors and consultants are generally held in high esteem and valued by society and rightly so. So too are nurses; it is often said the nurses do a wonderful job. The same should apply to the HCAs and care workers. Too often it is heard “oh that would not apply to HCAs or care workers” on the basis they do not understand or have the ability etc. Frankly, they are under paid and under valued and they do a far more difficult job than they are given credit for.
4. Adopt the culture and ethos of the Nuclear and Aero industries towards safety: determine the fault that caused an accident or breach of safety rather than apportioning blame and punishment. Evidence from these industries shows that staff and companies are
more transparent and open about mistakes and faults rather than seeking the protection of secrecy and denial.

5. Ensure gagging clauses are banned from all contracts.²

6. Work with and take note of charities but not to the exclusion of users speaking from their own experiences.³

7. Improve communication. When someone is ill, especially if old and frail, patience and understanding need to be the order of the day.

Final thought and comments
Much practice and care is sloppy, slap happy and slapdash. Much is made of the lack of money and not being able to afford “it”. But surely can we afford to not afford “it”? Despite all the positives in the health system there are systemic faults. Perhaps the main group to blame for examples of poor care is the public. If the public not just requested/demanded good quality care but were also quick to support staff with problems when they needed our support, many faults could be cleared and rectified.

The carer with 25 years experience told me that, when she started as a Nursing Auxiliary, staff operated in the care home without a qualified night nurse on duty. When she had sufficient experience she would deal with the doctor directly and when a resident died she would write out the death report. How things have changed.

Says it all in some ways.

² Francis Report, Page 104 Rec 179.
³ Francis Report, Page 46 Item 1.19.