As a former carer I looked forward to reading the Francis report with great interest and anticipation. Would it really be thorough, identify what surely must have been going wrong from all the reports I had heard, and identify major failings and faults?

The media reported, for example, that patients were not even getting drinks of water when needed and resorted to drinking water from flower vases.

I have to confess I have not read the full report so my comments are based solely on the Executive Summary. Having read the Executive Summary, however, I am sure the inquiry and the report are thorough; what was going wrong, major failings and faults have been satisfactorily identified. I need not have been concerned about a lukewarm report that really no one could be blamed; my high hopes of an honest and worthwhile report have been justified.

I am sure there are many who may think: “Thank God it is not like that in my area”. But how confident can we be about that? The report states:

the public is unlikely to have confidence that “another Stafford” does not exist, in the absence of being convincingly persuaded that sufficient change has taken place.²

There were questions over the number of deaths:

Local scrutiny committees and public involvement groups detected no systemic failings. In the end, the truth was uncovered in part by attention being paid to the true implications of its mortality rates, but mainly because of the persistent complaints made by a very determined group of patients and those close to them.³
Individuals with concerns were important: tribute is paid “to the work of Julie Bailey” who helped expose the neglect and failures of care.4

The carer’s view
What are patients, carers and former carers like me (to my wife who had Alzheimer’s) to make of the report and how relevant is it to our own experiences in our areas? The first point is that the charges against Mid Staffordshire Trust seem absolutely proved, and secondly, there are similarities with our own experiences.

Carers have seen and experienced very poor standards of care and often found it difficult to be listened to. Even when raising issues in a constructive and cooperative manner, we are ignored and the factual is denied. Problems at Morecambe Bay hospital give further strength to the argument that faults within hospitals are widespread.5

But such criticisms are by no means limited to hospitals and, of course, the NHS. The same standards and criticisms have to be levied against community care; care homes and domiciliary care. My local papers, the Crawley News and Crawley Observer, on 19th June 2013 reported that West Sussex County Council have begun “the process of removing 52 council-funded residents out of Oakhurst Grange Nursing Home” which is a private BUPA home in Crawley catering for residents with dementia.6 This follows “concerns for the safety of residents and a string of damning inspections by the CQC7 from July 2012 and February 2013.” BUPA announced to the staff on the 17th June that they were closing the home on 31st July.

My wife was a resident with Alzheimer’s at the home from 2002 to 2008. Admissions were stopped at the home in 2005 and again in 2009. It had very bad CQC reports during 2012. The County Council, Social Services and the CQC obviously felt the home was just not up to improving despite working with the home since last year, and in previous years.

At the beginning of June 2013, Radio “4 File on 4” reported on Orchard View care home, Copthorne, also near where I live. The new Southern Cross home opened in 2010 and closed 18 months later because of poor

4 Francis Report, Executive Summary, page 9, para 12
5 Morecambe Bay Inquiry Action http://www.morecambebayinquiry.co.uk/
6 BBC News Sussex, 'Urine-soaked' patients at Bupa Crawley care home, 26th June 2013 http://www.bbc.co.uk/news/uk-england-sussex-23064878#story_continues_1
7 Care Quality Commission
quality. Some of the staff were arrested but charges were finally dropped earlier this year. Southern Cross (until it ceased trading) and BUPA were 2 of the largest providers of care homes in this country for residents with dementia.

Does this mean that poor care is a natural consequence of dementia and mental illness, something that just has to be tolerated? If so, why is it that some staff do provide high standard quality care whilst many others fail to do so, working under the same conditions? Poor quality care is avoidable and must not be tolerated; poor care is also costly and good quality can be provided and can save money.

From a carer’s perspective, what are we to make of all this? The Francis report has identified poor quality and failings at so many levels that it is understandable if some consider the NHS (although in reality all medical care) is rotten at all levels. Yet virtually everyone surely must know examples of good and even exceptional quality care. But many people needing medical services will wonder whether they will get good reliable care or bad care; or more likely some good and some bad care.

How true is the statement that it is surprising that an inherently first class medical care industry should produce such shockingly bad care, a situation which certainly would not happen in any other major industry? On reflection, think of the Jimmy Savile case, Levenson report, the performance of the banks’ top management answering questions about the banks’ financial difficulties. A common theme in all of this is “we did not know” and “no one could have foreseen or predicted”. These reasons are get out of jail cards played far too often.

There is something deeper than just pouring scorn and criticisms on the medical world. It is a question of society at large. It is human nature to be defensive, claim to be unaware or not seeing, and even denying any wrongdoing, but it is not morally or ethically right. No matter how understandable such explanations or justifications are, there comes a time when the line of acceptability is crossed. That line was crossed at Mid Staffordshire and at two local care homes near me; I feel sure there are many similar examples throughout the country, for example at Morecambe Bay.

The public are right to feel concerned. It is understandable if they are on the defensive at times. But what is the role of the public? The Francis report supports patient involvement but also notes the representative groups failed to identify faults at Mid Staffordshire so the public have
questions to answer too. At the Royal College of Psychiatrists’ Carers Forum meeting on 11th June 2013 more than one carer remarked that some carers, meaning relatives, are sometimes part of the problem; the Forum is conscious of our responsibilities too.

The conundrum at Oakhurst Grange is that some of the care was excellent, of the highest order. Speaking from experience, that was in spite of some poor management decisions. In my view, the carers should be excluded from blame; it is the responsibility of senior staff and the management to ensure good quality care is the order of the day.

I am reminded of the biblical quote, ‘The poor you will always have with you’. 8 I suppose poor care will always be with us but at the same time it is worth remembering that where there is poor care there is often good care and where care is good, bad care can be found.

**Final thoughts**

I say three cheers for the Francis report and the legal team. I do however wonder if the report is too good and near the bone to be fully accepted and implemented by those who have the responsibility and the authority to act constructively on it.

I have the following suggestions:

1. There is an urgent need to study the ‘Summary of findings’ particularly the “Lessons learned and related key recommendations”. 9

2. Accept and implement the recommendations under the “Table of recommendations”. 10

3. Professionals and providers of medical care must be more receptive to comments by patients and their relatives acting as their carers. Far too often family carers in particular are met with denials or unhelpful responses to queries which then turn into complaints that lead to conflict.

4. There is an urgent need to work together and, where that is already happening, to improve working together.

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8 Mark 14:7, Matthew 26:11  
9 Francis Report, Executive Summary, page 65 onwards  
10 Francis Report, Executive Summary, page 85 onwards.
5. This may well be controversial, but recommendations 207 and 208 refer to the identification and relationship of Health Care Assistants (HCA) with nurses. This is also applicable to ‘care workers’ in care homes. HCAs in hospitals and care workers in community care should return to be known as Nursing Assistants/Auxiliaries as they used to be a few years ago. HCA means very little to much of the public and, like care workers in the community, does not indicate the nursing support function of the work that they do. Nursing assistant or auxiliary indicates immediately their relationship to a nursing function.

The Francis report is a golden opportunity to raise the standards of medical care, to remove the culture of tolerating poor care. Adopting the recommendations may not in itself totally eradicate such a discredited culture, but they could raise standards that are worthwhile achieving.

Talking to HCAs and the care workers in open ended discussions and listening to them could well produce good results. Their essential contributions seem to have been understated in the report yet they provide the direct hands on care.

Omens for the future, when previous inquiries are recalled, are not good. But that should not stop us trying. Surely it is better to address such issues and not succeed as much as we wish, than not to have tried at all. There is always the chance of achieving some improvements.