Editorial - The death of professionalism?

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The publication of the report by Robert Francis QC into the failings at the Mid Staffordshire NHS Foundation Trust has been sobering for all of us who work in the NHS.

The first Francis report itemised the full horror of lack of care and the subsequent impact in terms of suffering and death which followed. This latest report had a different brief – to try to determine what were the underlying causes of this lack of care.

There are many concentric and overlapping circles of responsibility in patient care. The immediate responsibility lies with the healthcare assistant, nurse, doctor or whoever is directly dealing (or failing to deal) with the patient. Beyond them the Trust Board and senior management are responsible. A large part of the blame is placed by Francis at the Trust's door and its concentration on meeting targets, not least financial targets in its application for Foundation status. Staff morale was low and there was a culture of fear, secrecy and bullying. The consultant body largely dissociated itself from management and there was an acceptance of poor standards.

Behind the Trust there was a plethora of supervisory and commissioning bodies who should have been aware that all was not well but they failed to act – the Strategic Health Authority, the Primary Care Trust, the Care Quality Commission, Monitor, the Department of Health itself and others.

There had been warning signs – the Trust lost its star rating and the Royal College of Surgeons had issued a disturbing report into the "dysfunctional" department of surgery. But these signs were ignored or explained away.

Interestingly Francis indicates that a contributory factor to the poor care was the abolition of Community Health Councils. The CHCs at least provided some sort of forum for a local community to have a formal influence on local health policies. Francis indicates that the successor bodies to CHCs are a very poor replacement. Indeed he says: *It is now quite clear that what replaced them ... failed to produce an improved voice for patients and the public, but achieved the opposite.*

Hardly anyone emerges from the report unscathed – including the GMC, the Nursing and Midwifery Council, Deaneries, Universities, the Health and Safety Executive, local authorities and others. Following the latest NHS reorganisation and the Health and Social Care Act the names of many of the bodies have changed, but the issues remain the same.

But what lessons can we take home from this report? Francis makes it clear that, although he had a limited remit and could not comment on failings elsewhere, he had no reason to think that Mid Staffs was unique. Sadly this is almost certainly true. Although in our own Trust we may have avoided the headline-grabbing disaster of Mid Staffs there are perhaps some echoes of it closer to home.

What can we do to ensure that the same thing does not happen here? Those in senior management will do their best to ensure that mechanisms are in place to enable staff and patients to make concerns known so that they can be acted on quickly. But all of us involved with patients must make sure we show real care and act professionally at all times. Some of the behaviour exhibited by staff on the wards in Mid Staffs cannot be blamed simply on "the system" even if the system did nothing to encourage a genuinely caring attitude. Such an attitude cannot be legislated for, and if it does not come naturally one would have to question whether the person is in the right job. It is sad to think that the Government has to consider enshrining a statutory "duty of candour" in law and it is difficult to see how this would work in practice.

The Secretary of State told the Commons that Mid Staffs should not be a byword for failure but a catalyst for change. Let us hope that it is. But maybe the change should be not so much in our institutions as in us?