LEICESTER MEDICAL SCHOOL

STUDENT AND STAFF

RESPONSE TO THE FRANCIS REPORT

Produced February 2014 and updated February 2016
BACKGROUND

The Francis Report was published on 6 February 2013 and there is no doubt that its findings were both shocking and upsetting. The report produced 290 recommendations, 281 of which have been accepted by the Government response. The overall findings of the report are best summarised by “there should be a shared culture in which the patient is the priority in everything done, the staff put patients before themselves and staff will do everything in their power to protect patients from avoidable harm”. Although many of the problems referred to in the Francis Report resulted from the manner in which the Mid-Staffordshire NHS Foundation Trust was managed, the findings of the report do have significant implications for undergraduate medical education. The report specifically requires Medical Schools to work with care providers to ensure that students are able to feedback concerns about standards of care. Those recommendations from the Francis Report that have relevance to undergraduate medical education are tabulated in Appendix A.

CONSULTATION WITH STUDENTS

Leicester Medical School sought the views of its medical students. These consultations occurred in November and December 2013. In the case of first, second and third year students Professor London delivered a talk about the report. These talks were followed by small group discussion and debate. It was apparent that the student body were dismayed by the findings of the Francis Report. The first, second and third years were asked to consider the following issues in their discussion groups:

1. Student selection
2. Caring (emotional)
3. Interprofessional caring
4. Whistleblowing. ‘Carers’/student
5. Do you feel apprenticed?
6. Resilience
7. Caring (knowledge)
In the case of the fourth year students, the Medical School sought the views of students following a talk by the Rt. Hon Stephen Dorrell, Chairman of the Health Select Committee. Mr Dorrell spoke on “Implications of Francis Report for the Health Service” which analysed the current situation for those working and those receiving treatment in the health service before looking forward. He took questions from students. After the talk students were divided in to their usual 6 streams and they grouped themselves into 4 teams, each discussing one element of practice using example questions to focus their discussion. Two senior members of university and NHS staff facilitated as each team, in turn, led a discussion with the remaining members of the group. The discussion of the Francis Report recommendations at the Health Select Committee provided the basis for the 4 topics below:

1. Advocacy
2. Accountability
3. Responsibility
4. Transparency

OUTCOMES/RECOMMENDATIONS OF THE FIRST, SECOND AND THIRD YEARS DISCUSSION GROUPS

Student selection

- Observe group exercises/team working
- ? Different interview content for Graduates
- Blueprint interviews for Medical School; against the 6Cs (Caring, Compassion, Competence, Communication, Courage, Commitment)
- Make the comprehension station centred around ethics/caring
- See how students respond to criticism
- Build in tests of resilience to criticism
- Members of the public/patients should be interviewers
- Make more use of scenarios / breaking bad news
- Ask questions such as whose job is it to …. [i.e. look after patients]
- Obtain references from volunteer work undertaken
• An MMI station that assesses common sense
• A situational judgement test on caring followed by discussion
• Test ability to manage conflict
• MMIs for all international students

**Caring [emotional]**

• First year students spend ½ a day a week as an Health Care Assistant and second year students as a nurse assistant
• Needs to be *discussed* more in the curriculum
• Consultants discussing with students both caring and non-caring experiences
• “Debates” with Consultant and General Practitioners
• Recorded interviews with patients who have experienced both care and lack of care
• More flexibility in communication skills teaching to allow caring to become apparent
• Could this be assessed in exams?
• Teaching on apologising
• Ethics should be integrated throughout the course and not taught as a separate subject
• Discussions on the relationships between ethics and caring
• The emotional impact of disease
• Patients providing direct feedback to students on their caring or lack of it
• Arrogance in medical students needs addressing
• Include introduction to NHS in Induction week, e.g. NHS Core Values
• Allow students to feedback to each other

**Interprofessional caring**

• Need to remove the concept of hierarchy
• Need to address arrogance of some medical students
• Must be *real* it is not practical currently
• Students should be taught early on tasks such as baseline observations, manual handling, etc alongside other Health Care Professionals

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**Whistle-blowing**
- The Medical School needs a policy
- Need support for whistle-blowers
- How do students raise concerns about clinical events?
- How do medical students in the early years know what is and what is not acceptable behaviour by staff or students?
- How do medical students raise concern about their teachers?
- How should students raise concerns about each other?

**Apprenticeship**
- Many groups commented that the current course does not feel like an apprenticeship
- Many groups commented apprenticeship should be integrated into clinical teaching earlier in the course
- More apprenticeship/shadowing

**Resilience**
- Medical students should do “time on-call” just like FY1 doctors
- Get Foundation Year doctors to speak to students about their experiences
- Deliberately change tutorial groups in second year
- At the same time as teaching students candour/transparency/openness the Medical School needs to teach students how to deal with uncertainty, errors/mistakes
- Student mental health issues are not dealt with robustly / increased openness and discussion of mental health problems
- Exam resilience does not equate to life resilience!

**Caring [knowledge]**
- Needs to be a clear link between knowledge and application to caring
OUTCOME/RECOMMENDATIONS OF THE FOURTH YEAR DISCUSSION GROUPS

1. Advocacy
A number of groups raised the interesting question as to whether doctors should be judged on how well they collaborate with the system [team working] or how “troublesome” they are on behalf of patients. Students asked whether the Medical School should specifically prepare students to be patient advocates when they qualify. This would mean that students need to be resilient! Students were concerned that if a student raised concerns about the care of a patient that this might have adverse consequences for that student.

2. Accountability
Many groups raised the issue whether doctors should specifically be accountable for the actions of colleagues if they have been aware that a colleague’s action impaired patient safety. Almost all groups believed that doctors, specifically senior doctors, should be accountable for the actions of colleagues.

3. Responsibility
Much of the discussion under this heading centred around the role of qualified doctors in hospital management. The majority of students felt that doctors are not managers and have not had the training to be so. Only two groups suggested that management skills should be taught at undergraduate level. Most groups felt that the role of the Medical School is to produce caring, competent and safe doctors and that management skills should be taught at postgraduate level.

4. Transparency
Interestingly, the discussion on transparency was very clear cut. The majority of students were against the publication of individual (and named) doctors’ performances and therefore it was no surprise that there was universal disagreement with public analysis of medical students’ performance by the public. The reasons cited included their student status and the public’s lack of knowledge regarding an undergraduate medical course. When it was pointed out that law students may have their undergraduate records scrutinised by potential employers, some students conceded that this should be equally applicable in medicine. Many groups were concerned that
poorly performing students are not removed from the course. There was a strong feeling that poorly performing students “get away with it”.

**MEDICAL SCHOOL RESPONSE**

Based on the students’ views, changes to the curriculum have already been and will continue to be made. For example, in the area of student selection the MMI process will address issues such as conflict management and resilience. In addition, patients will be involved in the selection process. Within the curriculum itself, first year students will spend half-a-day a week as volunteer care assistants and during the second year as volunteer assistant nurses on the wards. Students have requested specific instruction on how to apologise to patients and additional teaching on the emotional impact of disease. Many students reported that arrogance amongst their peers has to be addressed and also felt that there should be clearer pathways for raising concerns about fellow students, doctors and for raising concerns about patient care and clinical events. This has been addressed by the Medical School: [Raising concerns](#)

There was a strong feeling from the student body that there should be more apprenticeship within the curriculum and again this will be addressed with the curriculum revision. In respect of developing resilience, suggestions ranged from deliberately changing tutorial groups in the second year and asking foundation year doctors to speak to students about their experiences.

Having delivered the lectures regarding the Francis Report and having helped analyse the outcome of the discussion groups, Medical School staff have been extremely impressed by the professional and caring attitude of our students. The student body seems determined to do their best to care for patients and the Medical School is equally determined to work with the student body to achieve this end. The Medical School was surprised that many students felt that poorly performing students were “getting away with it” and this will need to be addressed in our forthcoming Curriculum Redesign. The other surprise was that fourth year students were, generally, uneasy about the transparency of an individual doctor’s performance. It is incumbent on the Medical School to strive to engender an
atmosphere of openness and transparency from the day that our medical students start their training.

I will update further Medical School actions on this web site as they are introduced into the curriculum.

Professor NJM London
Head of Leicester Medical School

7 February 2014

Update, February 2016

- **Raising concerns:** Sir Robert Francis published *Freedom to Speak Up* in February 2015. This document addresses the difficulties posed by and possible solutions to raising concerns. The Medical School has updated its document *Raising concerns* in response to this.

- **Apologising to patients:** In the new Curriculum starting in September 2016, the compassionate caring holistic detective (CHHD course) has been introduced. The purpose of the CHHD course is to help students learn how to interact effectively with patients, colleagues and other health professionals so that their care of patients may be optimised, rather than teaching “communication skills” which risks the perception that such learning is purely about verbal communication skills. The course aspires to bring students an understanding that effective interactions in the best interest of their patients include interactions between, not just patients, but other health professionals and where appropriate relatives. The course also aspires to bring students an understanding that effective patient interaction begins event before a doctor meets a patient and that effective interaction involves gathering altogether non-verbal and verbal communication in order to set the patient interaction in its social and cultural context. Learning how to apologise to patients will be part of this course.
• **Emotional impact of disease:** The emotional impact of disease will be addressed in all of the students’ learning. Lectures in Phase 1 about for example breast cancer or psoriasis will always begin with the impact on the patient and/or family. The medical school is currently collecting video footage of patients with numerous different diseases explaining the impact of their disease on them and their family.

• **Apprenticeship:** The new curriculum contains apprenticeship throughout the new Phase 2 [9 months of apprenticeship] and the three 7-week Foundation Year Apprenticeships in Phase 4.

• **Poorly performing students are “getting away with it”:** The Medical School has worked to strengthen and clarify its regulations concerning academic progression (see [Progression Regulations](#)). In addition the Health and Conduct Committee has replaced the Professionalism Concerns Group (see [Health and Conduct Committee](#)). The Fitness to Practise regulations have been substantially revised (see [Fitness to Practise](#)).

• **Resilience:** Resilience forms part of the Health Enhancement Programme (HEP) in Semester 1. Dealing with uncertainty is addressed in both the CHDD and HEP courses. Uncertainty will also form a core theme in the teaching of basic/clinical sciences. Students will do ‘on-call’ in their clinical apprenticeships. Foundation Year doctors will speak to students in their third and fourth weeks – this is part of the Very Early Clinical Experience (VECE course).

• **Mental Health Issues:** The Medical School is very concerned about the rising incidence of mental health problems in the University student population in general and in particular the rising incidence in the Medical Student Population. Because of this the Medical School has increased the number of sessions that the Pastoral Support Unit offers and since 2013 has subscribed to the Big White Wall (see [Big White Wall](#)). The Medical School has met regularly with Occupational Health and has produced a document explaining the support provided for mental health problems.
(see *Illness in Medical Students*). The HEP is designed to help reduce stress and hopefully therefore mental health problems amongst students.

- **Volunteering:** This was discussed at length with UHL. Unfortunately, despite the Medical School’s best efforts it did not prove possible to put into place a programme of volunteering in Phase 1. However, Very Early Clinical Experience [VECE] will provide students with many of the experiences that volunteering would have delivered.
APPENDIX A

RECOMMENDATIONS FROM THE FRANCIS REPORT THAT ARE RELEVANT TO UNDERGRADUATE MEDICAL EDUCATION

| Implementing the recommendations | • All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work.  
• Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions.  
• A shared culture in which the patient is the priority in everything done.  
• A system which recognises and applies the values of transparency, honesty and candour.  
• Staff put patients before themselves.  
• They will do everything in their power to protect patients from avoidable harm.  
• They will be honest and open with patients regardless of the consequences for themselves.  
• Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so.  
• They will apply the NHS values in all their work. |
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<td>Fundamental standards of behaviour</td>
<td>Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.</td>
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<td>The nature of standards</td>
<td>Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance.</td>
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<td>Need to share information between regulators</td>
<td>Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful.</td>
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| Medical training | • Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.  
• The Secretary of State should by statutory instrument specify all medical education and training regulators as relevant bodies for the purpose of their statutory duty to co-operate. Information sharing |
between the deanery, commissioners, the General Medical Council, the Care Quality Commission and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities.

| Teaching and training establishments as a source of safety information | • The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.  
• Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The General Medical Council should consult the Care Quality Commission in developing the survey and routinely share information obtained with healthcare regulators.  
• Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.  

Training visits should make an important contribution to the protection of patients:

• Obtaining information directly from trainees should remain a valuable source of information – but it should not be the only method used.  
• Visits to, and observation of, the actual training environment would enable visitors to detect poor practice from which both patients and trainees should be sheltered.  
• The opportunity can be taken to share and disseminate good practice with trainers and management.  

Visits of this nature will encourage the transparency that is so vital to the preservation of minimum standards.

The General Medical Council should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised, must take appropriate action to ensure these concerns are properly addressed.

| Safe staff numbers and skills | The General Medical Council’s system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training. |
**Openness, transparency and candour**

**Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

**Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

**Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

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<th>Principles of openness, transparency and candour</th>
<th>Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.</th>
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**Caring for the elderly**

Approaches applicable to all patients but requiring special attention for the elderly

| Communication with and about patients | Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:  
  - All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|